AN EXPLORATION OF CLINICAL PSYCHOLOGIST AND EDUCATIONAL PSYCHOLOGIST CONSTRUCTS OF MENTAL HEALTH IN THE CONTEXT OF SECONDARY SCHOOL AGED CHILDREN

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ABSTRACT

Over the past decade, Mental Health (MH) has increasingly appeared on the 'school agenda', both in terms of rising levels of MH difficulties in the student population, and also the expectation that schools have a role to play in supporting good MH. MH is a term fraught with ambiguities leading to uncertainty around the most appropriate ways to provide support. A review of current literature reveals a wide range of definitions and interpretations, sometimes within the same team of supporting professionals.

The current study seeks to explore the perspectives held by two professional groups seemingly well placed to support young persons' (YPs') MH. Six Clinical Psychologists (CPs) and six Educational Psychologists (EPs) are interviewed, exploring their constructs of MH, and their perceptions of their own role and the roles of others in supporting secondary school aged YPs' MH. The data are analysed through Thematic Analysis.

Findings suggest that there are variations between the two professions' constructs of MH, and EPs in particular have no unified concept of MH. This is likely due to less experience or training in this area. CPs and EPs hold similar perceptions of the school's role for promoting good MH, and flagging up concerns to more specialist professionals when necessary. However, there are discrepancies in the EP and CP perceptions of each other's roles. The conflicting views appear to emerge through incomplete information about the other, and professional defensiveness in a context where resources and funding are scarce.

The current study suggests that these challenges can be addressed through: greater reflectivity on professional biases, exploration of MH constructs within other epistemological positions, and greater communication regarding professional roles, leading to clearer collaboration in supporting the MH of YP.

STUDENT DECLARATION

I declare that while registered as a research degree student at UEL, I have not been a registered or enrolled student for another award of this university or of any other academic or professional institution.

I declare that no material contained in this thesis has been used in any other submission for an academic award. This thesis is the result of my own work and investigation, except where otherwise stated. Other sources are acknowledged by explicit references in the text and a full reference list is appended.

I declare that my research required ethical approval from the University Research Ethics Committee (UREC) and confirmation of approval is embedded within the thesis.

Rebecca DeAnne Miller

Signature: ..... Date:

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ABBREVIATIONS

BPS	British Psychology Society
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CP	Clinical Psychologist
CYP	Children and Young People
DfE	Department for Education
DfEE	Department for Education and Employment
DoH	Department of Health
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EHCP	Education Health and Care Plan
ELSA	Emotional Literacy Support Assistant
EP	Educational Psychologist
EPS	Educational Psychology Service
EWB	Emotional Wellbeing
GT	Grounded Theory
HCPC	Health Care and Profession Council
IAPT	Improving Access to Psychological Therapies
IPA	Interpretive Phenomenological Analysis
LA	Local Authority
MH	Mental Health
MHLW	Mental Health Link Worker
NCTL	National College for Teaching and Leadership
NEET	Not in Employment, Education, or Training
NHS	National Health Service
OFSTED	Office for Standards in Education
PHE	Public Health England
PMHW	Primary Mental Health Worker
RQ	Research Question
SDQ	Strengths and Difficulties Questionnaire
SEND	Special Educational Needs and Disability
SENCo	Special Educational Needs Co-ordinator
TA	Thematic Analysis
TaMHS	Targeted Mental Health Services
TEP	Trainee Educational Psychologist
WHO	World Health Organisation
YP	Young Person

CHAPTER 1: INTRODUCTION

This chapter introduces the term 'mental health' (MH), highlighting contemporary tensions in reaching a definition. An explanation is given of the current national context of MH in adolescence, and the role schools play in this area; policy documents are examined; as are the anticipated supporting professional roles. An overview of the local context is given, with particular emphasis on MH services for the young person (YP).

The researcher's position on this area of exploration is clarified, presenting a rationale for conducting the current research. The aims of the study are laid out, providing explanation of the literature search to follow.

1.1 'MENTAL HEALTH': AN AMBIGUOUS PHRASE

The term MH is not entirely straightforward. Often associated with MH *difficulty* (Public Health Suffolk, 2015), MH is typically linked to statistics referring to levels of *need* and specialist services offering support for MH *illness*.

However, over the past decade, the term 'emotional well-being' (EWB) has become evident in the language of MH (Davies, 2014; Ecclestone & Hayes, 2009), referring to a state of *good* MH. Within the concept of EWB there are various different understandings: the World Health Organisation (WHO) (2012) suggests that "mental well-being is fundamental to good quality of life(…) emotional health and wellbeing among young people have implications for self-esteem, behaviour, attendance at school, educational achievement, social cohesion and future health and life chances" (p.6); Public Health England (PHE) (2014) suggests that EWB is "children's subjective sense of how good they feel their lives are" (p.5); whereas the government initiated report, *No Health without Mental Health* (Department of Health (DoH), 2011) appears to equate 'good mental health' with the absence of 'mental illness'.

This ambiguity is likely in part due to the many different terms used to refer to, in theory, the same thing, dependent on the individual's epistemology. In her Annual Report, The Chief Medical Officer highlighted "there is a proliferation of terminology around mental health, some of which arises from disagreements about models of mental

health. Such variation in language can lead to confusion and lack of understanding" (Davies, 2014, p.2).

A further semantic ambiguity in current policy documents is the interpreted connection between 'mental health difficulties' (/-illness/-disorders/-distress/-problems, etc.) and 'emotional well-being' (/-positive mental health/-wellbeing/-emotional literacy/-positive psychological functioning, etc.) (Davies, 2014). Some policies refer to the two concepts on a continuum, as suggested in the *Foresight Report* (Government Office for Science, 2008), "achieving a small change in the average level of wellbeing across the population would produce a large decrease in the percentage with mental disorder, and also in the percentage who have sub-clinical disorder" (p.21). This report hypothesised that promoting well-being through developing a child's emotional literacy and resilience will result in reduced potential for a child to develop MH difficulties.

However, others argue that such a continuum lacks evidence (Davies, 2014; Wolpert, Humphrey, Belsky, & Deighton, 2013). Gray, Galton, McLaughlin, Clarke, and Symonds (2011) suggest that the available research in this area uses too many different measures and definitions of MH to provide any consensus in whether EWB and MH can be linked at all.

The variety in terminology and understanding of MH will, in part, be influenced by the different epistemological positions of the commissioners. For example, the medical model of MH adopts a more positivist approach – diagnosing a MH illness in order to identify an appropriate treatment path (National Health Service (NHS) Choices, 2015); whereas, a behavioural approach to MH understands symptoms to be behaviours, suggesting that learning new skills is helpful in managing maladaptive behaviours linked to MH difficulties.

1.1.1 HISTORICAL CONTEXT OF MH

Different professional groups tend to perceive MH differently, rooted in historical context. For example, whilst Clinical Psychology has grown dramatically in the United Kingdom over the past three decades, Pilgrim (2010) suggests that it continues to be defined by its origins: supporting psychiatric diagnosis through psychometric assessment. Service provision has moved a long way from the 'lunatic asylums' of the

1700s (Freeman, Felgoise, & Davis, 2008), and movements such as the emphasis on 'positive psychology' in the 2000s remind psychologists of their focus on the positive aspects of human functioning (Fredrickson, 2001). There is a growing shift away from psychiatric diagnosis (Johnstone, 2014) however, Harper (2010) suggests that Clinical Psychology fails to truly challenge biomedical reductionism for fear of undermining its own historical role. Consequently, Clinical Psychologists (CPs) appear in tension with the medical context in which it practices, tending to recognise MH difficulties within a bio-psycho-social model.

Historically Educational Psychology also focused on categorising individuals: identifying children's levels of need through assessment (Boyle, MacKay, & Lauchlan, 2008). This emphasis notably shifted in the 1970s when Gillham (1978) initiated a reconstruction of Educational Psychology, highlighting that Educational Psychologists (EPs) could usefully work at a more systemic level, focusing less on problems perceived to be within the child.

In the Underwood Report (1955), 'maladjusted' children were primarily considered to be most appropriately educated outside the mainstream. By the Education Act 1981, there was a growing acknowledgement that social and educational conditions contributed to children's difficulties, and there was a shift towards more inclusive education. Another major change was evident: "officially categories of handicap were replaced by assessment for 'special education needs' and 'statementing'" (Bennathan, Rimmer, & Cole, 2004, p.2), shifting away from finite labels.

Cole, Daniels and Visser (2012) note that over time, society has always classified a specific group of children: initially 'maladjusted' (The Education Act, 1994), then 'EBD' or 'SEBD', followed by the favoured 'BESD' (Department for Children, Schools and Families, DCSF, 2008). In 2007 there was an introduction of a major national strategy: The Social and Emotional Aspects of Learning (DCSF, 2007). EPs began adopting terms such as 'psychological wellbeing' or 'emotional health' to avoid the stigmatising associations of MH (Frederickson, Dunsmuir, & Baxter, 2009).

In 2014 the new Special Educational Needs and Disability Code of Practice (Department for Education & Department of Health, DfE & DoH, 2014) did away with the 'behavioural' aspect of BESD, referring instead to 'social, emotional and mental

health difficulties' (SEMH). Whilst it is emphasised that SEMH does not directly replace BESD, the change suggests a need to explore what behaviours communicate, identifying underlying unmet issues possibly including MH needs. MH is consequently on the EP and school agenda, however, historically this terminology is unfamiliar.

1.1.2 VARYING APPROACHES TO SUPPORTING MH

Evidently, the way in which MH is understood impacts the recommended support in this area. Previously, for example, the Children and Young People's Improving Access to Psychological Therapies (IAPT) provided Cognitive Behavioural Therapy (CBT) or parenting interventions (Pennine Care NHS Foundation Trust, n.d.) based on the understanding that promoting the management of thoughts and behaviours can reduce MH difficulties in children and YPs.

What works in promoting social and emotional well-being and responding to mental health problems in schools? (Weare, 2015) suggests that support should go beyond behavioural interventions:

> More appropriate responses provide both clear and rational consequences for poor behaviour and also look more deeply to see the whole child behind the behaviour, focus on their positive characteristics, and understand and address the underlying meanings, attitudes and feelings the behaviour represents (p.11).

The advice considers the two overlapping areas of school practice: "promoting positive social and emotional wellbeing for all in schools, and tackling the mental health problems of pupils in more serious difficulty" (Weare, 2015, p.1). The paper provides an understanding of MH and MH difficulties existing within systems, suggesting that schools have a role to play in changing the culture around MH through interactions with children and YPs.

1.1.3 MH: THE CURRENT STUDY

Rather than adopting a specific definition of MH in the current study, it is proposed that exploring relevant professionals' constructs of MH is an important way of identifying possible challenges in service delivery. The term 'MH' is used in this study to

encompass all aspects of promoting MH, and perceived poor MH is referred to as 'MH difficulties'.

1.2 THE NATIONAL CONTEXT

Over the past decade MH has increasingly featured in the UK's health policies. In 2010, the Coalition Government stated that their success would be measured by the nation's 'wellbeing'. The public health White Paper *Healthy Lives, Healthy People* (DoH, 2010) was the first public health strategy to give equal weight to both mental and physical health, leading to the policy document, *No Health without Mental Health* (DoH, 2011). The NHS *Five Year Forward View* (NHS England, 2014) was published in October 2014, establishing a Taskforce in March 2015 to develop a new strategy for MH (NHS England, 2015).

However, MH provision is consistently understood to be under pressure in the UK (British Broadcasting Corporation (BBC) News, 2016), with the MH of the adolescent age group raising particular concern. The recognised level of MH difficulties in children and adolescents has increased over the past two decades, evidenced in the last major survey of child and adolescent mental health carried out in the UK: in 2004, 11.7 per cent of children between 11 and 16 years old fulfil criteria for a MH disorder which justified assessment and treatment, compared to 11.2 percent in 1999 (Green, McGinnity, Meltzer, Ford, & Goodman, 2005).

1.2.1 ADOLESCENT MH

Adolescence, understood to be the period following the onset of puberty when an individual (referred to in this study as a 'young person') develops from a child into an adult (WHO, 2016), is a time of dramatic changes both socially and neurologically (Giedd, Keshavan, & Paus, 2008). Adolescence is a key period of remodelling in the brain, whereby changes take place in the memory systems, socioemotional processing, and emotional regulation (Nelson, Leibenluft, McClure, & Pine, 2005; Telzer, Goldenberg, Fuligni, Lieberman, & Gálvan, 2015) During this period, the YP is understood to become more independent, the social focus shifting from parents to peers, and begins to explore the role they will play as an adult (Erikson & Erikson, 1998). Tentative suggestions have been made that changes during this stage make a YP more

susceptible to MH difficulty (Nelson et al., 2005), and it is a formative time of developing resilience and strategies to enhance *good* MH (Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003). Furthermore, a YP's MH during adolescence is understood to predict MH needs in adulthood (DoH, 2011). Evidently, MH during this developmental stage warrants careful attention within health and education service provisions.

Only a small percentage of YPs with MH needs access MH services (Green et al., 2005). The lack of funding available has led to frequent cuts to MH services, seeing 25% reduction in some areas of England between 2011 and 2013 (YoungMinds, 2013), and Child and Adolescent Mental Health Services (CAMHS) have increasingly struggled to meet the demands made on them, evidenced by steadily increasing waiting times (CAMHS Benchmarking Report, 2013).

1.2.2 MH IN SCHOOLS

With health resources continuing to be squeezed (YoungMinds, 2013), schools are increasingly considered appropriately placed in supporting the MH of YP. Schools' consistent contact with YPs implies they could influence YPs' MH (Department for Education (DfE), 2014) and MH is increasingly seen as relevant to schools, as it has a direct impact on learning (Hagell, Coleman, & Brooks, 2013; PHE, 2014).

The Green Paper for *Every Child Matters* (DfE, 2003) introduced the idea that schools play a key role in MH promotion and early intervention work. This was further established in the Children Act 2004, and evidenced through the large budget committed to the Targeted Mental Health Services (TaMHS) initiative launched in 2008, aiming to embed MH services in schools. More recently, the *Special Educational Needs and Disability (SEND) Code of Practice: 0 to 25 years* (DfE & DoH, 2014) coherently included MH on the schools' agenda.

A number of non-statutory guidelines have been published to support schools in this area of care. For example, in July 2014, the DfE released a document providing guidance for schools to identify and manage MH difficulties within the school setting; this is currently revised annually (DfE, 2014). Further recent guidance and initiatives include *What works in promoting social and emotional well-being and responding to*

mental health problems in schools? (Weare, 2015); *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing* (DoH, 2015); *The link between pupil health and wellbeing and attainment: a briefing for head teachers, governors and staff in education settings* (PHE, 2014); and *Counselling in schools: a blueprint for the future* (DfE, 2015).

These documents provide a wealth of research, recommendations, and resources, however the issue remains: there are ambiguities, and occasionally contradictions, in the way in which MH and EWB are understood. For example, the DfE (2014) advises schools to "use the Strengths and Difficulties Questionnaires (SDQ) to help them judge whether individual pupils might be suffering from a diagnosable mental health problem" (p.6), encouraging a view that the problem is within the child. Whereas, *What works in promoting social and emotional well-being and responding to mental health problems in schools?* emphasises reduction of stigma in the area of MH through whole school approaches, and promoting the wellbeing of staff to enable effective support for the students: "with adults modelling the skills and attitudes they wish to impart(…) staying open minded, calm and reflective helps staff not to take challenges personally, better manage the associated emotional stress in themselves and remain in professional mode" (Weare, 2015, p.11). Schools are often left unsure of which advice or approach to adhere to (Hunter, Playle, Sanches, Cahill, & McGowan, 2008).

1.2.3 THE ROLE OF PROFESSIONALS SUPPORTING SCHOOL STAFF

A further ambiguity in the policy documents outlining schools' support of MH, is the anticipated role of other professionals. CAMHS is mentioned sporadically throughout, sometimes in the context of providing a diagnosis (DfE, 2014); other times providing "services during and after treatment" in schools (DfE, 2015, p.28). However, research in this area suggests that CAMHS is difficult for schools to access (Ford, Hamilton, Meltzer, & Goodman, 2008; Vostanis et al., 2010) potentially due to limited resources and the lack of clarity around the necessary referral pathways.

An evaluation of the TaMHS programme found that schools rarely refer children with emotional and behavioural difficulties directly to CAMHS and were more likely to make use of Educational Psychology services (EPSs) (DfE, 2011). However, reference to EPSs is sparse in the policy and guidance documents. For example, *Mental health*

and behaviour in schools: Departmental advice for school staff suggests: "it may be possible for schools to use the services of a Local Authority educational psychologist or to commission one directly themselves, depending on local arrangements" (DfE, 2014, p.23). It is possible that national policy cannot be more explicit due to the wide range of service models across different local authorities.

What works in promoting social and emotional well-being and responding to mental health problems in school? (Weare, 2015) is unique in outlining both the referral process for CAMHS services, the role of the Educational Psychologist (EP), and the anticipated involvement of the school in these processes:

> A pupil whose problems are greater than in-school support [can manage] can be referred to the GP and thence possibly to CAMHS. It is important to anchor these services in the schools, and ensure that any commissioned counselling or mental health services are fully integrated into the fabric of the school. Having specialist staff such as educational psychologists work with the young person at school is an approach which both the national and some local evaluations of TaMHS showed to be transformative in many cases. (Weare, 2015, p.11)

The following section will briefly explore the model of service provision in the Local Authority (LA) within which the current study took place. This will provide insight into the application of national policies and the resources available for supporting the area of adolescent MH.

1.3 THE LOCAL CONTEXT OF SERVICE PROVISION FOR ADOLESCENT MH

1.3.1 LOCAL PROVISION FOR MH DIFFICULTY

Recently, the MH trust within which the LA exists was branded 'inadequate' by the Care Quality Commission due to insufficient staffing levels, concerns around medication management, seclusion and restraint practice, and a lack of beds. MH provision was disbanded into a small inpatient setting and outpatient services, offering community support for YP with less profound difficulties.

Access to these provisions is monitored by a triaging system, with a narrow set of qualifying criteria. A Common Assessment Framework is completed for YP who do not meet the threshold for inpatient or outpatient MH provision, setting up a Team Around

the Child which allows access to a Primary Mental Health Worker (PMHW). The PMHW team area is a preventative service that offers advice, consultation and training for professionals who are supporting YPs with mild to moderate MH difficulties with associated low levels of risk. They are also able to provide brief individual support or evidence based interventions.

The Community Paediatrics team is specifically available for YPs who experience developmental delays. This team is sub-divided into various pathways, each of which consist of Clinical Psychology, Speech and Language Therapy, Occupational Therapy and Physiotherapy. Support can be provided for the MH of YPs accessing these teams.

Clinical Psychologists (CPs) also sit within social care, providing targeted support for families deemed to have 'serious problems'. This support seeks to reduce unemployment and crime, improving aspirations and quality of life.

1.3.2 LOCAL PROVISIONS FOR PROMOTING MH

The MH service offers a self-referring 'wellbeing service', consisting of staff trained in IAPT. This provision offers stress control and wellbeing workshops, telephone support, group therapies and short term counselling for individuals aged 13 or over.

The Youth Offending Service works closely with the county's Children and Young People's (CYP) services, supporting YPs to make the 'right life choices' through facilitating multi-agency working. The service seeks to tackle social and family problems, peer group pressures, social exclusion, truancy and drug problems.

The LA's CYP services have recently undergone a restructure, broadly encompassing Early Years support, Looked After Children services, Specialist Teachers and the EPS, each providing resources for different groups of individuals. The EPS is able to offer training on MH, social and emotional development, resilience, adolescent development, attachment, mindfulness, loss and bereavement, and a wide range of interventions for both individuals and groups.

Previously, the LA was involved in the TaMHS pathfinder project, allowing health services to work closely with schools promoting MH and resilience, but funding has currently been put on hold.

This overview highlights the complexity of service provision involved in supporting adolescent MH. The referral pathways vary in clarity, and the threshold for access tends to be changeable within each provision, dependent on the resources and funding available.

1.4 JUSTIFICATION OF THE CURRENT STUDY

Evidently the MH of YPs is an important area, and schools appear to play an important role in providing support (Weist & Evans, 2005). However, whilst there are many guidance documents and possible services available to promote this initiative, the occurrence of MH difficulties in YPs appears to be rising (Green et al., 2005). The current study proposes to explore some of the possible factors which reduce the effectiveness of services supporting YPs' MH through schools.

1.4.1 RESEARCH RATIONALE

The researcher has a particular interest in the MH of YPs, having worked in an adolescent MH inpatient unit, and in a community based team supporting YPs with MH difficulties to avoid hospital admissions. Throughout these roles, education was increasingly perceived to be a protective factor for YPs: MH difficulties, combined with missed opportunities for developing skills and interests, was observed to provoke a sense of hopelessness and reduced desire for recovery; whereas maintained engagement with education settings appeared to build resilience and a sense of wellbeing in YPs.

The researcher chose to train as an EP, anticipating that this would involve equipping schools with the necessary insights for supporting YPs' MH. Psychology, defined as "the scientific study of people, the mind and behaviour" (British Psychology Society (BPS), n.d., para.1), is understood by the researcher to be a valuable discipline in understanding the concept of MH. However, as EP training progressed, it became evident to the researcher that MH is not as evident in the job as expected; she questions whether the CP plays a more direct role than the EP in supporting schools to understand

YPs' MH needs. It is noted that CPs and EPs have similar skillsets and there are ongoing discussions around combining the doctoral training courses (National College for Teaching and Leadership (NCTL), 2015), however their access pathways and areas of working tend to be different (Health and Care Professional Council (HCPC), 2015). The researcher queries who is best positioned to provide this important area of support to schools.

In an area fraught with ambiguity, it is hypothesised that contrasting understandings of MH and uncertainty of professional roles reduces the efficiency of service provision in this area of adolescent MH. The current research therefore proposes to explore how EPs and CPs construct a concept of MH, and how they perceive themselves to support this area in the context of secondary schools.

1.4.2 RESEARCHER'S POSITION

In exploratory, qualitative research, the researcher will inevitably impact the research process. Therefore it is important to reflect on one's own biases and the influence these may have (Charmaz, 2006). The researcher is a trainee EP, with a particular interest in developing a role which allows her to support YPs' MH in schools. The impact of this position will be considered throughout the research journey, and reflected on in more detail in the concluding chapter (section 5.3).

1.5 CONCLUSION

This chapter introduces the ambiguous concept of MH, suggesting that adolescence is a significant period for MH promotion, or the possible development of MH difficulties. Schools are identified as an appropriately positioned provision to support the MH of this age group. However, the variety in possible approaches to achieving this, and the range of services which could feasibly offer support, creates a confusing terrain for both the school and the YP. The current study proposes to explore and clarify the perspectives and roles of EPs and CPs working in this area.

The next chapter will explore the systematic literature review conducted, focusing on current research into the integration of MH support in schools, with particular emphasis on the perspectives of the individuals involved.

CHAPTER 2: LITERATURE REVIEW

As explored in the previous chapter, current policy documents outline a growing emphasis on schools providing support for the MH of their students. However, in practice, questions have arisen around the definition of MH, whose role it is to support YPs in schools, and what provision should look like. A literature review evaluates and interprets the existing body of research around integrating MH into secondary schools.

This chapter will first outline the methods used in the systematic literature search, including the rationale for the inclusion and exclusion criteria adopted. The relevant articles found will then be critiqued in detail, considering the findings in relation to the paper's strength of evidence and theoretical framework. Themes emerging from the existing literature will be summarised to provide justification for the present research and an overview of the research findings will conclude this chapter.

2.1 SYSTEMATIC LITERATURE SEARCH

2.1.1 INCLUSION CRITERIA

Prior to conducting a systematic search, literature in the area of MH was examined, revealing that the terms 'mental health' and 'wellbeing' referred to a large spectrum of concepts, and were sometimes used interchangeably. These two search terms captured articles referring to resilience, emotional literacy, and positive MH, all of which were concepts relevant to the study.

The current study seeks to explore schools' role in supporting this area and as outlined in the previous chapter, the MH of adolescents is particularly relevant in recent policies and initiatives. Therefore, the literature search included initiatives around MH in secondary schools, excluding research conducted in primary schools.

Initially, the literature search specifically considered the views of psychologists working with the MH of YPs in schools; however this search proved too narrow, and useful insights from other participants involved in the area were being overlooked. Therefore, no specific group of professionals, practitioners, or students were identified in the search terms.

Hamilton-Roberts (2012) suggests that what constitutes a successful provision will be subjectively different depending on those involved. It was therefore decided that research specifically examining the perspectives and constructs held by the relevant individuals would be useful. A thesaurus was consulted in identifying the various phrases used to refer to an individual's 'perspective'.

Therefore, the final Boolean search phrase used was:

(Mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion* OR experience*)

On-line electronic databases PsychInfo, PsychArticles, Education Research Complete, ERIC, PubMed, SCOPUS, Academic Search Complete, Child Development & Adolescent Studies, and British Education Index Complete were searched, as the most relevant sources of research for the current study. 2,037 studies were identified through this initial search.

2.1.2 EXCLUSION CRITERIA

Skimming through the articles showed that much of the research had been conducted in countries *other* than the United Kingdom. As this research is specifically considering British policy in the education system and MH service provision, it was decided that research carried out elsewhere would lack relevance. The Boolean search phrase was therefore adjusted to:

(Mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion OR experience) NOT (United States OR Australia)

The search was also amended to include only articles published after 2003: the year that the *Every Child Matters* (DfE, 2003) policy was published, a key document in placing MH promotion and early intervention work on the school's agenda.

Articles which were not published in peer reviewed journals were excluded, on the grounds that peer reviewed research tends to be better quality. Reviews were excluded, as were articles which were not in English, and research which was conducted with animals.

After these exclusion criteria had been applied and duplications had been removed, 916 articles remained.

The titles of these articles were checked manually, and when appropriate, the abstracts were considered in order to apply a second wave of exclusion criteria. At this stage a number of articles were excluded which did not: refer to mainstream secondary schools, mention the MH or EWB of students, involve the direct perspectives of individuals involved in this area, or were not conducted in the UK. Articles which assessed the objective success of a provision were also not included, as it is the *perspectives* held by those involved which were deemed relevant and useful. 27 articles were found to be appropriate. These abstracts were examined in greater depth applying the exclusion criteria once more, and the references were explored to identify any relevant papers which had, as yet, been overlooked.

A final 20 research papers were identified, which formed the body of the analysis below. (Please see Appendix A for a detailed trail of the steps taken to identify the relevant papers).

2.2 CRITIQUING THE RELEVANT LITERATURE

An initial examination of the 20 articles showed that policy initiatives are interpreted in different ways, with MH provision falling into four broad clusters: internal school staff supporting the needs of the students; external practitioners providing input in schools; whole school approaches; and joint working between education and health.

The majority of the papers sampled do not explicitly identify a theoretical framework, however, it is noted that the language used to refer to MH tends to indicate the way in which the researchers have conceptualised this area. Therefore, throughout the critical review, attention is paid to the way in which MH (including EWB) is introduced in each paper.

The twenty articles are critiqued within the four clusters identified above, providing an overview of the research conducted in this area and considering the implications of their findings.

2.2.1 CLUSTER ONE: INTERNAL SCHOOL STAFF SUPPORTING THE MENTAL HEALTH AND WELLBEING OF STUDENTS

2.2.1.1 Overview

Six articles examine the role of staff already employed within the school setting, providing perspectives from school nurses, teaching staff, pastoral staff and students. All of the studies consider the training needs of school staff and/or the successes and challenges of different MH initiatives within schools, for example, school-nurse drop-in sessions; or school staff playing a role in "Comprehensive CAMHS", a strategy involving primary care staff supporting MH problems in schools.

Three of the six studies use quantitative methodologies, involving large numbers of participants (between 120 and 590), specifically referring to MH difficulties and school staff needing to possess enough knowledge to identify this area of need.

Two further papers utilise a mixed method approach, one weighted on quantitative analysis involving 450 participants; the other weighted on qualitative analysis, considering six participants. Both studies combine statistical and qualitative analysis – either phenomenological or thematic. The final paper uses semi-structured interviews to gain an in-depth understanding of 14 school staff's perspectives.

The smaller scale studies, using primarily qualitative methodologies, appear to view MH and EWB as less 'within the child' (Kidger, Gunnell, Biddle, Campbell, & Donovan, 2009b; Partridge, 2012), considering the whole school ethos and the EWB of the staff in promoting MH.

A detailed overview of the six studies is available in Appendix B.

2.2.1.2 Analysis and implications

Whilst the six studies focus on different groups of participants, there are commonalities involving the capacity of staff, challenges at a systemic level, and conceptualising MH. These three themes are explored below.

2.2.1.2.1 The capacity of staff

School staff appear willing to engage in this area of MH. There is however a concern of limited knowledge, a lack of time, and a desire for further training. The student voice is valuably highlighted, indicating a reluctance to confide in teaching staff around this area, and concerns around a potential lack of confidentiality in the school setting (Kay, Morgan, Tripp, Davies, & Sykes, 2006).

Timson, Priest, and Clark-Carter (2012) focus primarily on MH *difficulty*, exploring professionals' response to self-harm. As the participant groups are from only one local A&E, CAMHS, and school, the results have limited generalisability. Nonetheless, the findings suggest that compared to A&E and CAMHS staff, teaching staff score lowest on perceived knowledge of self-harm, feeling the most ineffective and negative about supporting YPs in this area.

Partridge (2012) uses a psychodynamic theoretical perspective to consider how staff can effectively develop an understanding of their own emotional responses to supporting MH and how a supportive and sustainable school ethos can be built. The study identifies a concern for the capacity of teaching staff.

Supervision is identified as extremely important (Partridge, 2012) and EPs may be well positioned to offer this: "EPs have an understanding of how educational systems operate and the demands placed on staff as well as having an understanding of emotional, social and behavioural development" (Partridge, 2012, p.130). Training for staff around managing their own emotional wellbeing is also considered useful.

2.2.1.2.2 Challenges at a systemic level

In the current literature, clearer routes of communication and support from external services are considered necessary in equipping school staff to support pupils' MH.

Madge, Foreman, and Baksh (2008) find that school staff feel they need greater clarity on CAMHS referral criteria, and re-referral routes, more collaborative working with health services, and more support following a diagnosis. A possible limitation of this study is the presenting of a wide range of participants as a homogeneous group: a diverse school staff is referred to as the 'education group'. It is likely that in accessing CAMHS, for example, a Junior School Teacher will have a different experience to the Behaviour Education Support Team. However the views were analysed and presented together making it difficult to identity precisely where there is a need.

Kidger et al. (2009b) use an eco-systemic framework to explore the different systems impacting on support for YPs, acknowledging the governmental pressures on schools to drive up academic standards. Whilst it is broadly acknowledged that MH is intricately linked with academic output, identifying the necessary resources to meet both agendas is consistently perceived as difficult.

2.2.1.2.3 Conceptualising MH

School staff appear divided on the best way of supporting MH, with the majority of discussion focusing on managing MH *problems,* and the importance of school staff possessing enough knowledge to identify need (Haddad, Butler, & Tylee, 2010; Madge et al., 2008; Timson et al., 2012). However, where the research design allows, there is reference to the more holistic role of school staff, building relationships and trust with the students (Partridge, 2012).

It seems that a greater emphasis on managing MH *problems*, leads to teaching staff feeling more overwhelmed and ill equipped (Madge et al., 2008; Timson et al., 2012). Teachers feel more confidence in building positive relationships and a listening environment (Haddad et al., 2010). Communicating with YPs, and understanding normal child development is where their skills lie (Madge et al., 2008).

The constructs school staff hold of MH, whether support should be promoting good MH or managing MH difficulties, shapes where they seek support for their own training and emotional needs. For example, when MH is understood as changeable and important for everyone, staff are found to recognise the importance of their own MH, requesting good supervision (Partridge, 2012).

2.2.1.3 Summary

This cluster highlights that school staff perceive time, training, supervision and conflicting pressures as limiting their capacity to support MH. Teachers have varying understandings of their role in supporting MH, impacting their willingness to engage in this area.

Challenges are evident in school staff offering support: staff's wellbeing impacts directly on the YPs' MH. For example, staff withdraw support when feeling ill-equipped (Partridge, 2012). The students' perception of the teacher's role, and student understanding of how a MH agenda should be tackled also impacts their willingness to engage with school staff in this area (Kay et al., 2006).

A reoccurring limitation in this cluster is the lack of clarity around the participant groups. The larger samples group a variety of participants together, whilst the smaller studies lack clarity around whose views are reported throughout the analyses. This reduces the potential for generalisability, or generating action points from research findings.

The quantitative methodologies are useful in gathering the views of a large number of participants, however, at times this removes the potential for participants to evidence attitudes and understandings of MH *other* than those outlined in the questionnaires and surveys. Further research could better contextualise the way in which MH is conceptualised prior to engaging in discussions about the resources and support necessary to improve provision.

2.2.2 CLUSTER TWO: EXTERNAL PRACTITIONERS PROVIDING INPUT IN SCHOOLS

2.2.2.1 Overview

An approach which features in the literature is an external practitioner providing support in the school, both for staff and YPs, with reference to MH. Six papers, published between 2008 and 2014, research this area. Five consider the role of EPs or trainee Educational Psychologists (TEPs), and a sixth examines the perspectives of a school-based counselling service.

Three of the papers explore EPs' experiences of providing therapeutic approaches in schools, two use a mixed method approach, one a qualitative methodology. A fourth study examines this same topic from the teacher's perspective (Rothì, Leavey, & Best, 2008). Data analyses includes Interpretive Phenomenological Analysis (IPA) and Thematic Analysis (TA). The researchers hold a variety of perspectives of MH, despite the research examining this seemingly similar area. Two papers explicitly suggest that MH difficulties require therapeutic treatment, approaching MH as a within-person difficulty; whereas the other two suggest that therapeutic approaches may be used to enhance Social and Emotional Aspects of Learning (SEAL).

The final two studies refer to EWB, exploring Emotional Literacy Support Assistants' (ELSAs') experiences of EP led supervision, the experiences of school-based counsellors and the relevant link teachers. Both papers use a mixed methods methodology, the former with a participant group of 270 ELSAs, the latter, 13 participants.

A detailed overview of the studies is available in Appendix C.

2.2.2.2 Analysis and implications

Most of the papers in this cluster focus on the EP role, with little reference to other external agencies providing support, possibly due to EPs' current drive to increase their evidence based practice (Frederickson, 2002). This high representation of EPs could be

misleading, as the EPs' role in this area is no more prominent in current policy than, for example, the CPs'. Future research could usefully explore other professionals' views.

An analysis of the six papers highlights two main themes which could inform future research: the challenges faced in external services providing support in schools, and the variety of ways in which this input is offered.

2.2.2.2.1 Challenges in providing an external service

In most of the papers, input from a service external to the school is limited by tensions between the different systems involved. A key challenge is the lack of resources within the school and the external service, thus a 'fire-fighting approach' becomes the norm rather than investing in preventative strategies. School staff feel they do not have time to implement recommendations (Rothì et al., 2008), requiring an external professional to come in and 'fix' a problem through direct work with the YPs, allowing teachers to distance themselves from the 'problem' (Squires & Dunsmuir, 2011).

Poor communication between services is considered a limiting factor in effective working (Atkinson, Squires, Bragg, Wasilewski, & Muscutt, 2013; Rothì et al., 2008); and a lack of information around what support is being offered (Atkinson et al., 2013; Squires & Dunsmuir, 2011). This appears to lead to some mistrust and frustration between the school setting and external practitioner (Rothì et al., 2008).

There is a lack of clarity around what is meant by MH and who is best positioned to support. Rothì et al. (2008) find that teaching staff construct MH in terms of illness, see it as beyond the remit of EPs, but feel forced to refer to EPs as they could not access health professionals. Conceptualising MH as a medical issue shapes the support which is sought and the anticipated outcomes.

These challenges are to some extent unresolved in the current literature, perhaps as most of the studies explore only one perspective leading to slightly unbalanced, problem saturated narratives. Future research could elicit a dialogue between the two parties, comparing the views of relevant professionals to find ways forward.

Hamilton-Roberts (2012) *does* compare the views of school counsellors and link teachers, finding that there is a mismatch between the teachers' perceptions of presenting issues, and the views of the pupils themselves, as reported by the school counsellor. Evidently, understanding the constructs held by different relevant parties is important in providing an effective service.

2.2.2.2.2 A variety of possible provisions

Four of the six articles explore therapeutic interventions in schools, so findings in this cluster emphasise the practicalities of this provision. A number of barriers are identified: the approach is time consuming; it is hard to provide a confidential space in the school environment; difficulties in the practitioners accessing clinical supervision; and schools being unwilling to pay for this provision (Atkinson, Squires, Bragg, Muscutt, & Wasilewski, 2014; Atkinson et al., 2013; Rothì et al., 2008; Squires & Dunsmuir, 2011). Whilst a few facilitating factors are identified, none of these papers critique what is meant by working in a therapeutic capacity, or why this is an appropriate means of supporting MH in schools. These seem important discussions, given the emphasis placed on this possible provision.

Two papers in the current cluster explore external support *other* than therapeutic intervention: Osborne and Burton (2014) find ELSAs feel valued and supported through EP supervision, benefiting from the opportunity to share ideas and problem solve in a group environment. Supervision from an external source could empower teaching staff to engage in this area of MH with greater confidence, creating a more sustainable model of provision.

Hamilton-Roberts (2012), examining the role of School-Based Counselling Services, places MH within an eco-systemic framework, impacted by and impacting upon family, relationships, learning potential and academic outcome. This highlights the variety of areas the counsellors are able to support with positive outcomes for the YP. However, there are few participants, the data is self-reported, and the interviews relatively short, providing only a small amount of data. Nonetheless this study suggests that external practitioners can effectively support schools to engage with MH at these different systems levels.

2.2.2.3 Summary

External practitioners assisting schools in managing MH adopt two different approaches: an 'add on' service to the support the school can offer, working directly with the YP; or considering the YP's needs more broadly, providing a more systemic provision (systemic work is understood here to be the process of supporting change which impacts both the YP and the systems around the YP; Balchin, Randall, & Turner, 2006).

The current literature suggests that the capacity of different services is unclear, with the range of different constructs of MH confusing expectations. An examination of these constructs could increase clarity, improving the utilisation of external support in schools.

2.2.3 CLUSTER THREE: WHOLE SCHOOL APPROACH

2.2.3.1 Overview

Four articles, published between 2009 and 2014, research three different methods of 'whole school approaches' to supporting MH within secondary schools:

- An inclusive ethos and listening culture
- Promotion of emotional health in the curriculum
- Tackling issues which might cause distress, such as bullying.

All four studies acknowledge a difference between promoting MH and managing MH difficulties, focusing on the former. This appears to have led to bias in the participant samples. For example, Kidger, Donovan, Biddle, Campbell, and Gunnell (2009a) conduct a phone survey of 17 schools who did not respond to their initial questionnaire, discovering that these schools did not view promoting MH as important. Similarly, Coombes, Appleton, Allen, and Yerrell (2013) acknowledge a likely bias in the self-selection nature of the participant groups, but suggest that hearing the perspectives from schools which have some experience of promoting MH will be more useful than those schools which have no experience.

All of the articles in this cluster examine the YP's voice, providing insight into their perceived needs, their understanding of MH, and the ways in which they feel able to engage in support. In Kidger et al. (2009a), the student participants were selected by staff leading to possible bias, and both Kidger et al. (2009a) and Coombes et al. (2013) acknowledge that the focus group approach promotes more persistent voices over others. Nonetheless, the YPs' perspectives in this cluster are insightful and useful.

Focus groups are used in three of the studies, one involving 154 students in addition to 15 staff interviews (Kidger et al., 2009a); and two exploring a small number of YPs' views in focus groups (Aston, 2014; Coombes et al., 2013). The fourth paper uses a web-based questionnaire in a quantitative methodology, to gather 304 YPs' views on the schools' bullying policies (Raynor & Wylie, 2012).

Analyses involved constructionist grounded theory (Aston, 2014); rigorous TA, checking inter-rater reliability through comparing two researchers' independent analysis of the same transcripts (Kidger et al., 2009a); a "top down" approach to TA, allowing the research questions to influence the emerging themes (Coombes et al., 2013); and statistical analysis, applying the Chi-squared and Fisher's exact tests to investigate the correlations between bullying and other factors (Raynor & Wylie, 2012).

A detailed overview of the studies is available in Appendix D.

2.2.3.2 Analysis and implications

Three main themes emerge from this cluster of research: exploring the possibility of shifting school ethos to promote MH; considering the benefits and challenges of including MH on the curriculum; and ongoing discussions around the meaning of MH in the context of schools.

2.2.3.2.1 A whole-school ethos of wellbeing

The literature explores the debate around the promotion of MH versus the prevention of difficulties (Aston, 2014; Coombes et al., 2013; Kidger et al., 2009a) concluding that there is a need to understand YPs' MH more holistically rather than tackling specific MH problems in schools.

YPs consistently state that they want normality (Kidger et al., 2009a), greater confidentiality (Aston, 2014; Coombes et al., 2013) and hold a fear of stigma (Kidger et al., 2009a). Interestingly semantics seem irrelevant to the YP: even when 'mental health' was not referred to "people will use it against you and like cuss us or something and say 'ah you have to go to your stupid emotional health thing'" (Kidger et al., 2009a, p.13). Receiving therapeutic interventions implies an unwanted vulnerability. Furthermore, when talking about a MH *difficulty*, YPs are more likely to talk to their peers rather than staff (Coombes et al., 2013).

These observations suggest that intervention for MH difficulties in a school setting is problematic for students, and approaching MH more holistically is helpful.

Achieving this whole-school approach to MH is not without challenge. School policies in this area are sometimes too theoretical and inaccessible to students (Raynor & Wylie, 2012). Unfortunately, Raynor and Wylie (2012) do not provide detail of the different policies assessed in their research, so further conclusions and recommendations cannot be gleaned from this paper. Kidger et al. (2009a) argue that schools need support in creating listening cultures and an inclusive ethos, requiring clearer guidance at a policy level.

2.2.3.2.2 Challenges in including MH on the curriculum

In this cluster, students suggest a range of ways in which they would appreciate support around MH, for example, Coombes et al. (2013) found that YPs want more information and support around MH difficulties and self-harm.

Students feel that any MH curriculum should be sensitively and confidentially provided and express reservations around staff being the facilitators (Kidger et al., 2009a). It is suggested that education and support around MH may be beyond the capacity of teaching staff – there is a feeling that some of the more sensitive topics are ignored because staff "can't handle it" (Coombes et al., 2013, p.229). It is suggested that ideally an external professional (Kidger et al., 2009a), or potentially a specialist staff member in school (Coombes et al., 2013) would be involved.

Health services are seen as responsible for producing new interventions for whole school approaches, but concerns are raised that they do not have a thorough understanding of the education system or a knowledge of the school environments' strengths and limitations (Aston, 2014).

2.2.3.2.3 A broader understanding of MH

The researchers in this cluster demonstrate an openness towards defining MH, for example, Kidger et al. (2009a) state that "the notion of emotional health work was kept deliberately broad to ensure that all aspects that participants viewed as important were captured" (p.3). This approach proves valuable as, for example, Coombes et al. (2013) finds that students consider MH to be an important area, but hold a wide range of constructs and do not associate it with an emotional state or resilience. Aston (2014) observes that "adolescents generally used informal language compared to language used by adults or professionals concerning mental health" (p.298) often providing a much clearer definition. This suggests a need to clarify what is understood by MH in the education context, and acknowledge that approaches to support in this environment may need to be adjusted accordingly.

A reoccurring theme suggests that this area could be understood within a developmental model: YPs identify that they want guidance around their sexual identities (Coombes et al., 2013); and Aston (2014) argues that staff need a knowledge of identity, relations and adolescent development. A developmental model underpinning any whole-school approach may equip staff with a greater understanding of expected progress and typical behaviour, enhancing their capacity to 'normalise' any MH support provided.

2.2.3.3 Summary

Whilst whole-school approaches to MH are demonstrated to be useful, there is relatively little research available or unity around how this could be achieved. Aston (2014) and Kidger et al. (2009a) suggest that if schools are to tackle MH, a shift of school ethos is most effective, whereas Coombes et al. (2013) argue for the inclusion of MH in the school curriculum.

If, as the YPs suggest, an external professional would be most appropriate to facilitate a MH curriculum, an exploration of professionals best positioned for these roles would be helpful.

Further findings suggest that there may be scope for facilitating YPs supporting each other (Coombes et al., 2013), or, possibly, work needs to be done in supporting the broader relationship between staff and pupils (Kidger et al., 2009a) to build trust and mutual respect.

In this cluster there remains an ambiguity around the meaning of MH, for example, Kidger et al. (2009a) refer in their focus groups to "helping students to feel good or happy" (p.15), appearing to equate this to meaning good MH, without further clarification. This lack of clarity continues to pose a difficulty in offering a rigorous evidence base for the most effective ways of meeting YPs' needs in this area.

2.2.4 CLUSTER FOUR: JOINT WORKING BETWEEN EDUCATION AND HEALTH

2.2.4.1 Overview

The four papers in this cluster, published between 2008 and 2012, examine the more general aspects of joint working between education and health, considering, for example, the existing knowledge base and training needs for the two services to work together effectively (Vostanis et al., 2010) and the introduction of a Mental Health Link Worker (MHLW) in schools (Hunter et al., 2008).

Two papers in this cluster examine the perspectives of professionals working within health (Van Roosmalen, Gardner, Elahi, & Day, 2012; Vostanis et al., 2010), and two involve participants from both health and education (Hunter et al., 2008; Vostanis, et al., 2012). Education is notably under-represented within this cluster (15 staff in Hunter et al., 2008; and eight compared to the 52 CAMHS professionals in Vostanis et al., 2012).

A limiting factor throughout the research in this cluster is the representation of participants as homogenous groups, either 'education staff' or 'health workers', despite the wide range of professionals within the participant samples. For example, a selection

of psychologists, psychotherapists, PMHWs and nurses are referred to as 'CAMHS clinicians' (Van Roosmalen et al., 2012) disregarding the wide variations in their training and experiences. Similarly, Vostanis et al. (2012) refer to the experiences of 'educationalists' but it is unclear who these individuals are.

Three papers in this cluster are qualitative, two utilising semi-structured interviews (Van Roosmalen et al., 2012; Vostanis et al., 2012) and one, a focus group (Hunter et al., 2008). TA is used (Vostanis et al., 2012) and Grounded Theory (GT) (Van Roosmalen et al., 2012) in exploring clinician views on a school-based MH service. It is unclear which analysis method was used by Hunter et al. (2008), and the fourth paper gathers quantitative data using questionnaires, including some qualitative responses and the use of vignettes in order to expand on the responses given (Vostanis et al., 2010).

Three of the papers use quite medical language considering specific MH disorders, the need for clearer identification of 'problems', and the impact MH difficulties have on academic attainment. Van Roosmalen et al. (2012), however, suggest that MH can be promoted, basing their research within a system relations model, exploring the support of Tier 2 CAMHS in schools at different systems levels.

A detailed overview of the studies is available in Appendix E.

2.2.4.2 Analysis and implications

The main discussion which emerges from this cluster is the facilitating and limiting factors in effective joint working between health and education.

2.2.4.2.1 Ambiguity around job roles as a limiting factor

In this cluster, it is repeatedly stated that joint working is hampered by differing beliefs and attitudes around individuals' job remits, and the ways that MH should best be supported.

Hunter et al. (2008) find that CAMHS workers and education staff have inconsistent expectations of how health professionals are integrating into schools. It is suggested that the school's role is to identify the difficulty and make a referral, with the MHLW

communicating between services (Vostanis et al., 2012), "redressing the split in the system" (Van Roosmalen et al., 2012, p.37), and providing information around diagnosis. However, Hunter et al. (2008) find that the consultancy role of the MHLW is often overlooked as pressures require them instead to 'case carry'. Similarly, Van Roosmalen et al. (2012) find that the CAMHS clinicians in the Tier 2 integrated team are given more direct work than they can manage. Direct work delivered by health services in schools may not be sustainable, as the breadth of the MHLW and PMHW's roles continue to be expanded.

Practitioners' own beliefs and attitudes have an impact on the role they play. For example, CAMHS workers participating in Vostanis et al. (2010)'s study place differing levels of priority on developing a knowledge of the education system. The participant group in this study is broad, without providing a breakdown of the specific professionals, so it is not possible to see whether the training priorities differ according to role.

Hunter et al. (2008) discover that teachers feel a disconnection between policy expectations and reality: "regardless of what policy tells us, this mental health stuff is new to us. It's a new set of responsibilities and skills" (p.673). The constantly changing expectations on professionals in this area leads to uncertainty around job roles.

Part of this ambiguity stems from contrasting constructs of MH, as Hunter et al. (2008) discover through focus groups of education staff and CAMHS workers: "Mental health terminology was seen to be a problem, with different modes of language often forming a barrier between education and health staff" (p.674). Future research could consider this further as, introducing a link worker for example, will not fix discrepancies in language. A further question might be: do the incongruities go beyond semantics?

2.2.4.2.2 'Building a relationship' as a facilitator

Clarity around the involvement of the 'other', through dialogue and building relationships, is seen as a facilitator in all four of the research papers. Vostanis et al. (2012) find that CAMHS workers have greater empathy for education professionals after developing a clearer understanding of the job role, and "understanding children within an educational context had altered how they carried out assessments and

considered intervention planning" (p.120). The interviews in this study are carried out *after* the participants had attended a relevant training programme, potentially biasing the responses given in the interviews, but helpfully allowing them the opportunity to reflect on the positives of joint-training.

Similarly, CAHMS workers who have a positive perception of education staff tend to feel more confident working with schools, rather than those who perceive themselves simply to have had appropriate training in this area (Vostanis et al., 2010). Building relationships between health and education professionals may be key in facilitating joint working.

The clinical participants in Van Roosmalen et al. (2012) suggest that their Tier 2 CAMHS service is most successfully implemented in schools through training staff to improve their approaches to students' MH and supporting schools to develop mentally healthy environments. This point is only raised in the 'validation group' *after* the data analysis, whereby the participants realise that this aspect of their role has not emerged as a theme from their initial interviews. The theme is subsequently included. It may be queried whether this is a valid finding; alternatively, it may be perceived as a particularly important outcome, as it warrants being added. Nonetheless, this outcome may be perceived as the health service developing better practice through a clearer understanding of the education setting.

Finally, an advantage of health and education working together is found to be the demystifying of MH among Primary Care services, "by improving knowledge about appropriate medical, psychological well-being and development of children" (Van Roosmalen et al., 2012, p.39). A shared language, in addition to a clearer understanding of each other's roles, appears to reduce stigma.

2.2.4.3 Summary

The research in this cluster highlights that ambiguities in job roles and varied understandings of MH have a detrimental impact on effective joint working. This sense of ambiguity was evident in the research papers, as roles such as the MHLW (Hunter et al., 2008) were poorly defined, causing the reader some uncertainty. Further investigation would be useful, with a more specific focus on the beliefs and attitudes

held by professionals working in this area, and a greater clarity around their understanding of their own job roles.

EPs are implicitly absent from research in this cluster. For example, participants in Vostanis et al. (2012)'s training programme debate the importance of appropriately positioned professionals with a breadth of knowledge in education and MH, describing aspects of the EP's job role – however the profession is not mentioned. This demonstrates the importance of building relationships and knowledge of one another's roles to prevent duplication of resources and missed opportunities for joint working.

2.3 CONCLUSION

A number of key messages emerge from previous literature which explore supporting MH in secondary schools:

- Teachers feel some uncertainty around their role in supporting MH, requiring more information (Timson et al., 2012), clearer understanding of their own role and others' (Hunter et al., 2008), better support for their own MH (Partridge, 2012), and greater clarity around referral pathways (Madge et al., 2008).
- School staff resort to using health professionals as a 'fire-fighting intervention' when they feel too overwhelmed to manage MH (Rothì et al., 2008), sometimes misunderstanding health's role (Hunter et al., 2008). Similarly, health professionals are found to have a limited understanding of school systems (Vostanis et al., 2010).
- Poor communication between services and confusion around roles raises difficulty (Atkinson et al., 2013; Hunter et al., 2008). Building relationships is found to be a facilitator for improved working between health and education (Vostanis et al., 2012; Vostanis et al., 2010).
- MH is consistently an ambiguous term, with little clarified meaning in the literature, and various conflicting interpretations (Coombes et al., 2013; Hunter et al., 2008; Partridge, 2012). The theoretical positions of the researchers are infrequently stated explicitly, but their approaches appear to range from medicalised, to post-positivist epistemologies, to social constructionist positioning. The failure to clarify these positions adds to the ambiguity in MH literature.

- There is little exploration of which approaches are most appropriate or effective for supporting MH in schools. However various challenges are identified both with therapeutic interventions within school (Kidger et al., 2009a; Rothì et al., 2008), and facilitating change at a more systemic level (Raynor & Wylie, 2012; Squires & Dunsmuir, 2011).

The current study aims to bring greater understanding to these areas of uncertainty through exploring EP and CP views of MH, their own roles in supporting schools, and the roles they perceive schools as playing.

2.4 RESEARCH QUESTIONS (RQS)

Based on the above literature search, the current study explores the following questions from the perspectives of Clinical Psychologists and Educational Psychologists:

1. How do Clinical Psychologists and Educational Psychologists construct "mental health"?
2. What are Clinical Psychologist and Educational Psychologist practices when working in the area of MH in secondary schools?
3. In what ways do Clinical Psychologists and Educational Psychologists have a shared understanding of the different roles in the area of MH in secondary schools?

The following chapter outlines how this exploratory research is conducted.

CHAPTER 3: METHODOLOGY

This chapter reiterates the aims of the current research and outlines the research design considered most appropriate to elicit answers to the RQs. The epistemological and ontological position adopted is examined, justifying the research design used. The chapter details the procedures of sampling, data collection and analysis, highlighting the importance of quality research and concludes with ethical considerations for the research process.

3.1 RESEARCH AIM

Existing literature demonstrates that there are ambiguities not only in the way in which MH is understood (Coombes et al., 2013), but also in the roles different professionals expect to play when supporting MH in secondary schools (Hunter et al., 2008; Vostanis et al., 2012). There appears to be a disconnection between policy and reality, poor communication between services (Madge et al., 2008) and an overarching sense that schools feel overwhelmed (Hunter et al., 2008).

The current research will therefore explore CPs' and EPs' understanding of MH in the context of the role they perceive themselves and others to have in supporting YPs in secondary schools. It is anticipated that acknowledging the inevitable variations occurring in these constructs could inform future provision in this area.

3.2 ONTOLOGICAL AND EPISTEMOLOGICAL FRAMEWORK

Morgan (2007) refers to the 20th century philosopher, Thomas Kuhn, popularising the concept of a *paradigm* as "a way to summarize researchers' beliefs about their efforts to create knowledge" (Morgan, 2007, p.50). The most common way of defining one's paradigm is through depicting one's ontology (the way in which reality is viewed) and one's epistemology (the understanding of how knowledge is created) (Matthews, 2003). A researcher's philosophical paradigm guides and directs thinking and action, shaping the entire research design and must therefore be established in the initial planning stage.

The paradigms of positivism and social constructionism are briefly examined before concluding that critical realism is adopted for the current research.

3.2.1 POSITIVISM

Historically, Educational Psychology research was conducted within a positivist framework, seeking to find the most accurate ways of categorising children according to ability and need (Boyle, MacKay, & Lauchlan, 2008) and reflecting the empiricist approach to science which dominated the early 1900s. This paradigm, referred to as *positivism* and succeeded by *post-positivism,* presents the ontology of one reality which can be identified and quantified, and the epistemology that knowledge must be gained through controlling variables and measuring realities in an objective manner (Mertens, 2010).

Positivist research tends to produce quantitative results and is best applied to large scale studies where context has little relevance to the phenomenon under scrutiny (Mertens, 2010). There is an assumption that the researcher can be entirely objective, suggesting that data collection can be replicated, producing the same results if two different researchers used the same methodology. *Post-positivists* place less emphasis on the necessity for the researcher to be entirely objective, accepting that the researcher's values and background knowledge will influence the data they observe. However, they maintain that one reality exists and can be identified through research (Robson, 2002).

The current research does not adopt this approach, as it is evident from the literature review that there are vast discrepancies in the way in which MH is conceptualised, which impacts how support in this area is offered. It cannot be claimed that there is one objective reality of MH. Perspectives held by individuals are inevitably shaped by training, personal and professional experiences, belief systems and cultural influences. At the data collection stage, a positivist approach would seek to quantify and measure the most successful ways of supporting children in this area, requiring a definitive understanding of both MH and how it should be tackled. Such a united concept does not exist.

Within the data analysis phase, the positivist approach would dismiss 'anomalies' in results as failed predictions of reality (Morgan, 2007). The current research, however, acknowledges each participant's reality of MH as being equally valid, not least because their 'reality' will shape the support they offer, influencing the 'realities' of the YPs

they work with. Contradictions and anomalies cannot be rejected as irrelevant, but should be recognised and explored.

3.2.2 SOCIAL CONSTRUCTIONISM

Initially, the proposed response to positivism was 'social constructionism' (Lincoln & Guba, 1985), arguing that there are multiple, socially constructed realities, and within research the investigator and participants interact, together constructing a reality (Mertens, 2010). Constructionism acknowledges that human interactions cannot be reduced down to "empirical regularities" (Robson, 2002, p.19), taking into account the infinite cultural, social and historical variations which shape 'reality'. Research conducted within this framework might use a case study approach, considering the minute detail of the individual's perspectives.

However, the constructionist paradigm is not without issue. Matthews (2003) raises a dilemma in the operationalising of constructionism in EP practice:

> The clients that the service works with, usually adopt a positivist realist view of reality. They agree to the involvement of an educational psychologist on the basis that they are contributing a professional perspective as opposed to simply providing another view that has no special status or legitimacy. (p.62)

The constructionist approach to research tends to produce descriptive results which are not easily evaluated, and are not generalisable. Furthermore, a constructionist approach rejects the need for reliable and valid data. Whilst the constructionist researcher would argue the *credibility* and *reflexivity* of their data (Robson, 2002), the regulatory body for EPs, The HCPC, emphasises the importance of rigorous evaluation of research in order to contribute to evidence based practice.

The current research acknowledges that the data is specifically relevant to the experience of working within the participants' LA, and the perspectives of the individuals involved. However, the data analysis seeks to understand MH better and elicit theory which may be generalisable and useful in other similar contexts, hoping to effect change. Therefore, a social constructionist approach will not be adopted.

3.2.3 CRITICAL REALISM

Critical realism, it is suggested, incorporates strengths from both the positivist and social constructionist approaches, accounting for human complexities whilst maintaining clinical excellence (Morgan, 2007). The critical realist ontology echoes the postpositivist paradigm that a reality does exist, but within the confines of a specific context, shaped by cultural, social and historical influences. In the current research MH is a concept widely acknowledged in Western culture, but its constructed meaning has changed over time, and varies widely across different professional disciplines and individual opinion (Salmon & Rapport, 2005). Critical realism would state that, as researchers, we can only imperfectly discover the individual's 'reality' of MH, we cannot 'prove' a theory, but can develop an understanding of a phenomenon by eliminating alternative explanations (Mertens, 2010). This could be attempted, for example, through semi-structured interviews, exploring the meaning of the participants' answers as they are given.

The critical realist paradigm also presents aspects of constructionism (Kelly & Woolfson, 2008) suggesting that, to some extent, reality can be viewed as interpretive based on the individual's experience of the phenomenon, and communicated in a particular way by the participant. The critical realist researcher accepts that s/he will only ever gain a distorted perception of the participant's reality. The researcher in the current study is careful to consider biases which are likely to influence the way in which information has been presented and understood. The critical realist acknowledges that the researcher is *not* value free, whilst still seeking to maintain rigorous methodologies.

In eliciting individuals' views, critical realists do not claim, as do constructionists, that all perceptions are equally valid – critical realism allows for the notion that some views may be subjugated. Guba and Lincoln (1994) critique both post-positivism and constructionism for positioning the researcher as a powerful expert researching powerless people. The critical realist epistemology, however, places an emphasis on questioning existing power imbalances, encouraging the observer of social relations to critique what is seen (Sayer, 2000) in order to empower the participant, incorporating features of the emancipatory approach. Furthermore, through giving voice to the different 'realities' that exist, professionals working to support adolescent MH may be

able to acknowledge their own subjectivities and discover ways of working together more effectively.

The outcome of research based on a critical realist paradigm is useful: the data collected is analysed over time in a cyclical manner, and the hypotheses are refined allowing knowledge to become more closely linked to reality (Matthews, 2003). Critical realists consider research to be reliable if it can be replicated. Whilst it is acknowledged that the context will never be exactly the same, it *is* possible to generalise findings and make comparisons between studies.

Critical realism endeavours to go beyond beliefs, experiences and current understanding of things, and say something about the actual things themselves. In the current study, it is argued that YP at times will benefit from support regarding their MH, and gathering the perspectives held by professionals working in this field may further our understanding of the 'reality' of service provision available to YP in secondary schools. The critical realist claims that to some extent people can effect change over the world, and it will be suggested that whilst the participants may hold a variety of different perspectives on MH, professionals must endeavour to move towards a more shared reality in order to provide effective, collaborative care for the YP.

3.3 RESEARCH DESIGN

A time-line of the current study is included as Appendix F.

3.3.1 QUALITATIVE EXPLORATORY DESIGN

The existing studies reviewed in the previous chapter explore the views of professionals in this area, but many adopt a quantitative approach presenting at least two limitations. In some studies, the perspectives of many different professionals are grouped together, disregarding that their differing experiences and beliefs shape the views that are held. Furthermore, research methods within a quantitative design tend to assume a shared understanding of the constructs being researched. This current study suggests that such an assumption cannot be made regarding MH and this is a limitation in some of the reviewed studies.

More generally, quantitative research tends to present many of the issues typical of adopting a positivist paradigm. Although the critical realist paradigm is an approach which can effectively use either qualitative or quantitative research approaches, as Greig, Taylor, and MacKay (2013) suggest: "quality refers to the essence of something – to questions about its nature and how it is experienced and described" (p.171). Qualitative research enables a deeper understanding of participants' experiences through words, rather than numbers and statistics. Greig et al. (2013) suggest that quantitative approaches are "abstract and cold" (p.171) and do very little to reveal to us a deeper understanding of the individual's views of the world.

In seeking to contextualise the views held by participants, Denzin and Lincoln (2000) state: "qualitative research is a situated activity that locates the observer in the world(…) a set of interpretive, material practices that make the world visible" (p.3). A qualitative approach is particularly valuable in understanding how and why the participants hold the views that they express in the current research.

Therefore, in exploring EPs' and CPs' constructs of MH, and their role in supporting YPs within a secondary school setting, a qualitative research approach is considered appropriate, offering a richer exploration into the views held by the participants. In previous literature, it is the subtle differences in these constructs held by participants which appear to impact on the effectiveness of cohesive joint-agency working and positive outcomes for the YPs (Hunter et al., 2008).

3.3.2 RESEARCH PARTICIPANTS

Much of the literature considering MH in schools focuses on *problems* within the child, presenting research laden with medicalised, deficit language. However, there is growing evidence that the story of MH is far more complex than this (Davies, 2014). An appeal of involving psychologists in the current research is their training background within psychological frameworks. It is hypothesised that their conceptualisation of MH may have less of a 'within child' focus, possibly applying a positive psychology approach to the presenting dilemmas, thus providing new insights into the area.

The two different groups, CPs and EPs, are selected as two professions employed by different services, one associated with health, and the other with education. The

selection of these two professional groups is targeted, as much of the current research in this area considers the narrative around joint working between health and education but selects very broad participant groups or fails to hear the voice of those professionals who are providing support. With the similarities in their training, comparisons between CPs and EPs are expected to highlight similarities and differences between the assumptions made by education and health around this area of service provision.

The BPS summarises psychology as "the scientific study of people, the mind and behaviour" (BPS, n.d., para.1). It is therefore assumed that applied psychologists who have involvement with YPs will have a role in supporting the area of MH. However in previous literature there are limited studies evidencing EP and CP perspectives on this area. Within this current climate of austerity, and the ever reducing availability of resources, it is considered important to identify gaps and overlap in support which is being offered to schools (NCTL, 2015). Current literature highlights various ambiguities and uncertainties around the different professionals' roles in this area.

Six CPs and six EPs are interviewed. In qualitative research, sample sizes are not as rigid as quantitative frameworks, but must still be considered carefully, as suggested by Patton (1990) "there are purposeful strategies instead of methodological rules" (p.183). The purpose of the current research is to explore the perspectives and experiences around a specific phenomenon, documenting diversity and variation in professional opinion. It is therefore necessary to interview enough participants to see a breadth of views emerging. However, the study also proposes to understand a psychological perspective on this area of service provision, requiring a depth to the interviews and analysis which might be lost through large sample sizes (Smith & Osborn, 2008). It is therefore concluded that six participants should be selected from each group, giving a total of twelve participants, producing approximately twelve hours of data.

As there are significant variations in the way child and adolescent services are delivered across the UK, the current study selected participants from one LA. This allows an exploration of the variation in perspectives held by professionals despite a similar working environment, considering their expectations for joint-working within the same system. The study does not claim to produce results which can be generalised across different LAs, but to provide a detailed investigation into the interactions and

perceptions of professionals working within one model of service delivery, raising themes and trends which could be usefully investigated in different LAs.

It is acknowledged that the participants' training backgrounds will impact the perspectives which they hold. However, the service in which they practice, their areas of specialism, their years of service, their personal experiences, and many other factors will also influence their constructs of MH. Furthermore, it is not possible to quantify the extent to which each of these variables will impact views held. Therefore it was concluded that their training backgrounds would not be investigated in depth or accounted for during the sampling process.

The sample is selected through purposive sampling, using a maximum variation method. This is deemed appropriate as the population group is relatively specific: psychologists employed by the public sector within one LA, who have some working contact with adolescents in attendance of mainstream secondary schools. Within this relatively homogenous group any emerging *contrasts* and *variations* in perspectives are interesting and warrant further exploration. Furthermore, by selecting a breadth of psychologists working within different teams in the LA, *common* themes which emerge are also of particular interest, "capturing the core experiences and central, shared aspects or impacts" (Patton, 1990, p.172), of supporting MH in secondary schools in that LA.

The maximum variation method has been operationalised through a 'snowball sampling' approach, whereby an 'information rich' key informant has been identified in both the CP and EP population groups, who has then been able to recommend individuals they felt would be valuable to the study (Patton, 1990). After contacting the suggested informants, requesting their involvement and enquiring if they had any further ideas of appropriate individuals, they too made recommendations, beginning to converge with the same names being mentioned repeatedly.

An invitation letter and a consent form (Appendix G) were emailed to each possible participant, outlining the purpose of the study and the nature of involvement. The majority agreed to participate, with the exception of two who felt they did not have enough experience of working with the adolescent age group, and one who was unable

to spare the time. A further two were replaced due to a period of sickness during the data collection phase.

The final group of EPs spanned three different geographical bases, with a range of years of experience, and a variety of specialist interests such as the Youth Offending Service, the Adoption Team, and Video Interactive Guidance. The CPs are employed by the NHS Foundation Trust, Social Care, or the Integrated Community Paediatric Service, with a similarly diverse range of specialist interests.

3.4 DATA GATHERING

Identifying an approach which effectively gathers data appropriate for the research purpose, is a process which warrants careful thought (Marshall & Rossman, 2011). A range of techniques were considered, concluding that semi-structured interviews would be best suited for the current research. A summary of this decision is outlined including a critique of the limitations and potential risks of interview techniques, a consideration of ways to overcome these difficulties, followed by a brief discussion of designing the interview.

3.4.1 A CASE FOR THE INTERVIEW TECHNIQUE

A questionnaire is useful in the context of studying the behaviour of large groups, or when seeking to make a prediction (Kvale, 1996), however the current research proposes to develop an in-depth understanding of a few individuals. Observation tends to be best suited to discovering complex interactions or behaviours within a natural social setting (Marshall & Rossman, 2011). This is not relevant to the current research which sought to elicit information around the *perceptions* of the participants, rather than their objective behaviours.

Kvale (1996) argues that interviews are "particularly suited for studying people's understanding of the meanings in their lived world, describing their experiences and self-understanding, and clarifying and elaborating their own perspective on their lived world" (p.105). From a critical realist epistemology, the current research argues that to gain the most accurate possible insight into a reality, it must be elicited directly from the individual who has lived it.

An interview can be seen as a form of conversation, providing a useful platform to check testimonial validity. As topics are discussed, both the interviewer and interviewee are able to check meaning, increasing the potential for discovering a slightly less distorted perception of the participant's reality.

The interview process can be a largely positive experience for the participant, producing good catalytic validity. As suggested by Kvale (1996), "just listening to what people have to say for an extended period of time, as well as the quality of the listening, can make an interview a unique experience" (p.116). The interviews in the current research have appeared energizing, providing space for the participants to reflect on a topic they largely found interesting and stimulating. Comments have been made such as "I'm tired, in a good way – that really got me thinking", "it was interesting to think about all that, I'm not sure I had clarified my views before…". It is also interesting to note that participants appear to become clearer about their understanding of MH throughout the interview.

Data collected through interviews fits into the researcher's epistemology and ontology, and gathering relevant and appropriate data for the current research provides positive outcomes for the participants.

3.4.1.1 Semi-structured interviews

Interviews tend to be structured or semi-structured. Semi-structured interviews use an interview schedule, but initial questions can be modified in response to the participants' answers, following particular areas of interest and significance which arise (Smith & Osborn, 2008). Allowing a dialogue to develop is important in producing more genuine data, avoiding assumptions and predictions about the topics the participant might want to discuss. Semi-structured interviews are therefore deemed appropriate for the current research. Each interview was recorded with an audio device in order to capture a high level of detail.

3.4.2 WHY NOT PHENOMENOLOGICAL INTERVIEWING OR FOCUS GROUP?

Both phenomenological interviewing and the focus group approach may, arguably, have been used to gather data for the current research. A brief exploration of these alternative approaches is considered useful in consolidating the choice which has been made.

The current study involves elements of the phenomenological approach, "considering the meaning of a concept or phenomenon that several individuals share" (Marshall & Rossman, 2011, p.148). However, the current research seeks to explore not only the meaning of MH, but also the application of that meaning through participants' experiences of working in the school environment, and their understanding of others' roles. Descriptive information in addition to an interpretative element (Kvale, 1996) is therefore useful in the current research.

Focus group interviews have a number of advantages, allowing discussions to progress organically producing a richness of data. However, it was deemed less appropriate for the current study, as the participants' unique views are valuable. The inevitable "interaction effect" (Coombes et al., 2013) of a focus group may cause the participants to develop either more or less conformed views. Furthermore, focus groups could risk power dynamics which prevent the less dominant members of the group from expressing views (Marshall & Rossman, 2011). Finally, the current research sought to cover specific areas, and focus groups can feasibly spend time on a range of topics which are deemed irrelevant to the research.

3.4.3 CONSIDERATIONS OF ETHICS AND QUALITY WHEN CONDUCTING INTERVIEWS

There are a number of cautions which must be considered in conducting research with semi-structured interviews.

It is often claimed that research interviews lack objectivity, or a freedom from bias. Phenomenological reduction, "an attempt to place the common sense and scientific foreknowledge about the phenomena within parentheses in order to arrive at an unprejudiced description of the essence of the phenomena" (Kvale, 1996, p.54) may be applied in adopting an objective stance, acknowledging the influence that the researcher

may have. The critical realist epistemology acknowledges that the researcher can never be truly objective, but through critically analysing one's own presuppositions and foreknowledge, the researcher can minimise his or her biasing in the data collection phase, creating space for the participant's voice. The biases and assumptions of the researcher will be outlined and acknowledged in section 5.3.

The quality of the data collected through interviews is largely impacted by the skill of the interviewer and the questions which are asked. The interview process involves the interviewer making many quick choices around which avenues to pursue, how, and why. Furthermore, in keeping with the critical realist epistemology, part of the interpretation might occur within the interview as the interviewer attempts to verify her understandings of the subjects' answers.

In the current research, these hurdles have been predominantly overcome through careful planning and a wide knowledge of the subject area, as will be outlined below. As a practical aid, the researcher has made very brief notes during the interview to prompt a return to particular comments without disrupting the flow of the interviewee's response. More generally, the researcher has found relevant training on the doctoral psychology course an aid to conducting an interview appropriately. Skills in summarising, active listening, steering and hypothesising (Egan, 2013) are pertinent to both EP practice and quality interviewing.

Generally, interview subjects vary in their response to the research conditions. It has been discovered that the main difficulty in the current research is not a lack of eloquence, but wide variations in the participants' willingness to share personal insights and opinions. One or two of the interviewees initially shared only factual information about their job role, so the interviewer carefully motivated more in-depth reflections to be considered.

The relational, conversational quality of an interview presents both strengths and risks within this method of data collection. As highlighted previously, the interaction allows for checking of interpretations, and often provides a pleasant experience for the interviewee. The interviewer will ideally be open, engaging and sincere, creating a reflective space which is rewarding for both the interviewer and interviewee. However, Kvale (1996) suggests that in some situations "the openness and intimacy of the

interview may be seductive and lead subjects to disclose information they may later regret" (p.116). The interviewer has therefore been cautious not to go 'too far' with enquiries. The consent letter reminds the participant that they can withdraw information up until the stage of analysis, and the letter has been referred to at the end of each interview.

A final challenge considered in conducting interviews has been the potentially cumbersome nature of carrying them out. Interviews are time consuming to conduct and analyse, and involve face-to-face interaction at a time convenient for two busy professionals, in the case of the current research. However, the advantages of the interview approach far outweigh these difficulties. Plenty of time has been given to complete the data collection phase, and the interviewer has travelled to the locations most convenient for the interviewee to reduce the inconvenience of participating.

3.4.4 PREPARATION FOR INTERVIEWING

A significant part of the interview process took place prior to meeting the participant. Various considerations in writing the interview schedule, and planning the interview meeting will now be outlined.

3.4.4.1 The interview schedule

In developing an interview schedule, the researcher must be clear about the purpose of the study and how involving the interviewee will progress towards that goal. The current research aimed to explore psychologists' constructs of MH, and their experiences of working with schools in this area, considering similarities and differences in the views they hold. The questions are therefore exploratory rather than testing hypotheses which had already been established.

Kvale (1996) suggests a continuum between intellectual and emotional dimensions. It is deemed inappropriate and unnecessary to seek spontaneous, emotional reactions about the topic in the current research. Questions exploring the experiences and perspectives of the participants are sufficient in answering the project's RQs.

In writing the interview schedule, the order of the questions is significant. The first question has been designed to help the participant feel comfortable with the topic area, providing the opportunity to establish his or her view of 'mental health and wellbeing', and develop a comfortable, coherent narrative for the rest of the interview. It was also been helpful for the interviewer to identify each participant's theoretical framework at the start, thus adopting the language they used and reducing the influence of her own forestructures and biases.

As outlined by Smith and Osborn (2008) the questions used have been neutral, avoiding jargon, and open in order to allow fuller answers. The final schedule (Appendix H) has then been memorised and used by the researcher merely as a prompt, enabling discussion to flow as naturally as possible.

3.4.4.2 Planning the interview meeting

Having written the interview schedule, various other preparations were necessary. A thorough knowledge of the area is important, including an understanding of: the theoretical perspectives around MH, an awareness of the local and national context, and a familiarity with some of the strategies used in schools currently. This provided the researcher with a greater confidence to pursue different thoughts and ideas presented by the participant.

Planning what information to share at the start of the interview was important, concluding that a little information about the research purpose is helpful in setting the participant at ease. As the project was an exploratory study into psychologists' perspectives, there was minimal risk that sharing the purpose would bias the participants' views.

During the briefing stage of the interview, the participant tended to offer an immediate reaction to the research topic as it appeared to be quite an emotive debate for professionals working in this area. This was been deemed acceptable as it was initiated and led by the interviewee, and allowed some rapport to be built prior to starting the interview. On a few occasions, the interviewee asked the researcher why she had chosen this particular area. A brief, neutral response concerning her professional background was offered.

Equally important was been planning a debrief following the interview. This again tended to be led by the participant, allowing a space for them to reflect on the experience, and express any concerns, generally a fear that they had 'waffled' too much! The researcher then concluded with thanks and the offer of a summary of results which would eventually be available to the participant.

3.5 PILOT STUDY

With the interview schedule broadly decided, a final step in its design involved piloting it with an EP colleague with the research still in its design stage (Hayes, 2000). This was a useful exercise as it was highlighted that the phrasing in one of the questions could elicit responses which are not relevant to the research aim. Furthermore, it was decided that a few more detailed probe questions should be included on the schedule to guide the interview when the conversation goes off topic.

3.6 DATA ANALYSIS

Kvale (1996) suggests that analysis takes place throughout an entire piece of research in a number of stages, through interpretation and clarification of meaning in the interviews, during the transcribing of the data, and throughout the verification and reporting of the interviews. Kvale (1996) suggests that this latter stage is often overemphasised as the way of finding meaning in interviews. However, whilst it is important to acknowledge the impact of these different stages, identifying a formalised method of analysis is essential in making coherent twelve hours of audio data.

In designing the research, a number of qualitative data analysis approaches were considered, concluding that TA is the most appropriate for the purpose of the current study. A brief summary of this decision process is outlined, highlighting the strengths and relevance of TA.

3.6.1 IDENTIFYING AN APPROPRIATE DATA ANALYSIS APPROACH

The IPA approach is closely connected to hermeneutics, seeking to understand how research participants make sense of particular experiences or events (Smith, Flowers, & Larkin, 2009). IPA tends to be used with a small, homogenous group with whom the

RQ will bear relevance, therefore focusing more on theoretical rather than empirical generalisability (Smith & Osborn, 2008). The current study is phenomenological to the extent that it looks to understand psychologists' subjective experiences of supporting MH in secondary schools; nonetheless the study has a broader focus: comparing the perspectives of two separate participant groups, considering the perceptions of their, and others', job role. In order to accommodate this wider breadth of information, the study to some degree, accepts the participants' comments at face value, not presuming to discover a deeper, subliminal meaning.

GT is another method considered as it focuses on developing a theory from the data (Corbin & Strauss, 2008). It is an approach which weaves an inductive process throughout the whole research journey, simultaneously collecting data and carrying out analysis. The current research adopts an inductive element. However, this is carried out through broader brushstrokes than in GT research: a number of psychologists are interviewed in order to elicit themes and trends. Furthermore, the data collection method does not involve grounding the research in the empirical world of the participants. Rather than getting "close to this life to know what is [empirically] going on in it" (Blumer, 1978, p.38), the current study is interested in the participants' constructs.

Another method considered was Discourse Analysis, which explores the linguistic construction of social realities through analysing the language which is used by participants (Potter & Wetherell, 1995). Whilst the current study is interested in the language used by psychologists to make sense of MH, the researcher does not adopt the philosophy that realities are entirely constructed by language. Furthermore, the study is interested in the broader application of how psychologists approach this area in the context of secondary schools.

TA is a flexible approach, broadly summarised as identifying themes which occur in the data. In some studies, themes are determined before the analysis begins, in others, themes emerge from the data through recurrent statements or concepts (Hayes, 2000). TA is useful in managing large data sets, creating an accessible and coherent summary (Osborne & Burton, 2014), whilst maintaining rich data. It has been deemed an appropriate approach for the current study, as it allows the researcher the flexibility to examine the phenomenology of the data and the language used by the participants, using an inductive process as themes emerge in a ground-up process.

3.6.2 USING THEMATIC ANALYSIS

TA is sometimes viewed as an unspecified method, leading to ambiguity and a lack of rigour. It can be understood to be a process which complements *all* approaches to qualitative analysis, without offering a coherent method in its own right. However, Boyatzis (1998) argues that TA can be consistently and reliably conducted, outlining a number of decisions which should be made whilst designing the research in order to ensure a rigorous process. Boyatzis (1998) suggests that one can adopt a theory-driven approach to TA, a prior-research-driven approach, or a data-driven approach, the latter of which is deemed appropriate for the current research.

The current study is an exploratory study, searching for new themes around psychologists working in secondary schools, rather than seeking to provide an explanation for a previously identified phenomenon, therefore an inductive approach was used.

To ensure the rigor and appropriateness of TA, a number of other decisions have been made prior to completing the analysis. On a practical level, the entire data set has been analysed to avoid researcher bias in selecting smaller, specific sections deemed as significant (Braun & Clarke, 2006). From a critical realist epistemological position, it is maintained that all views shared by the participant are relevant and significant.

Semantic analysis has been used, looking explicitly at the information the participants shared, rather than interpretative analysis examining underlying conceptualisations which shape the participants' views. This is considered sufficient as the sense that the participants consciously made of MH is understood to have had as much of an influence over their practice as the subliminal meanings they might hold. The analysis does, however, go beyond description, endeavouring to interpret the significance of patterns emerging from the data (Patton, 1990).

As stated previously, the development of themes and codes has not been based on the researcher's own theories and assumptions. Whilst this approach can be used quite effectively in other disciplines (Boyatzis, 1998), it may lead to lower interrater reliability and lower validity, thus the researcher's beliefs would be likely to bias the outcomes. Further, this particular topic of study does not lend itself to a specific

theoretical framework through which to explore the data. Rather, an inductive approach has been used, allowing themes to emerge from the data, developing "data-driven codes" (Boyatzis, 1998, p.41). These inductively developed codes are criterion-referenced according to the different professional groups' constructions of MH, and their perceived role in managing it.

Braun and Clarke (2006) propose a six-stage, iterative process of TA:

1. Becoming familiar with the data: through transcribing, checking material for accuracy, reading and re-reading, and noting down initial ideas.

2. Generating initial codes: coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.

3. Searching for themes: collating codes into potential themes, gathering all data relevant to each potential theme, according to participant sub-themes and overarching themes.

4. Reviewing themes: checking if the themes work in relation to the coded extracts and the entire data set; creating a thematic map.

5. Defining and naming themes: ongoing analysis to refine the specifics of each theme and the overall story the analysis tells – identifying the essence and the meaning of each theme, being able to describe each theme.

6. Producing the report: Providing an account of the data, using examples or extracts to produce an analytic narrative. (p.87)

These stages have been followed during the data analysis. (See Appendices I and J for samples of the data coding process). Four thematic maps have been produced: one map for each participant group regarding RQ1, and one map combining RQs 2 and 3 for each participant group. These thematic maps are examined in depth during the findings stage of the research process and presented in the following chapter.

3.7 CREDIBILITY AND DEPENDABILITY THROUGHOUT THE DATA ANALYSIS

Qualitative research does not tend to seek *validity* and *reliability*: within the critical realist ontology, reality is not perceived to be 'accurate', rather it is dependent on the perceptions and experiences of the participant. Therefore, the research strives for *credibility* (themes which emerge are based on converging evidence), and *dependability* (similar results would likely emerge if the data collection was systematically carried out and well documented, in a similar setting) (Robson, 2002). The various stages of data analysis of the current study are now considered with regards to achieving credibility and dependability.

As mentioned previously, the credibility of the data has been checked with the participants throughout the interview process, checking the researcher's interpretations as the conversation progressed.

After the data collection phase, it has been necessary to transcribe the data into written prose to aid the TA. It is important not to perceive this as a neutral process, acknowledging that the transcriptions are not the original data, "every transcription from one context to another involves a series of judgements and decisions" (Kvale, 1996 p.163). The dependability of the data has been ensured through a number of steps. It has been decided that the initial transcription should be carried out by someone other than the researcher, bringing a greater objectivity to the task. Three transcribers have been used who had no connection to the data; each were given specific guidelines outlining the level of detail required (see Appendix K). The data was transcribed in full, paying attention to the way in which statements are delivered, including emotion, hesitations and natural breaks (Hepburn, 2004) to add clarity to the intended meaning of the participants' statements (see Appendix L for an example transcription).

Ten minutes of one of the data sets has been transcribed by a transcriber *and* the researcher independently to compare the number of words typed, checking the objective accuracy of the transcribing. The researcher has gone through the transcriptions to check the way in which different pauses, less audible words, and non-verbal utterances had been interpreted by the transcriber.

The researcher does not claim to be entirely objective, acknowledging the active role which is played in identifying patterns in the data, and has therefore been transparent about the assumptions made throughout the process of TA. A written record of emerging themes and thought processes has been kept (Robson, 2002; see Appendix M for a sample of this commentary). It is hoped that this clear paper trail allows the research to be rigorously evaluated and encourage the reflexivity of the researcher to ensure the dependability of the data.

After the codes and themes are identified, their dependability has been constantly tested through applying them back to raw data in an iterative cycle. Further, a peer and the Director of Study have coded small sets of the data, also then applying the researcher's codes to the same material. This cross validation allowed reflection on the consistency in the researcher's judgments (Boyatzis, 1998).

In the presenting of the research, quotations from the interviews are included to support the themes identified. This allows the reader scope either to share the viewpoint and interpretation, or potentially disagree (Squires & Dunsmuir, 2011).

3.8 REFLEXIVITY

From a critical realist position, the researcher believes 'reality' to be found through the interactive link between the researcher and the participant and the researcher can only hope to gain a distorted perception of the participants' realities (Kelly & Woolfson, 2008). The critical realist acknowledges that the researcher is *not* value free, requiring a constant reflexivity, examining the ways in which they will impact the reality.

The researcher has spent time considering possible ways she could impact the data, identifying her biases and forestructures. A careful paper trail is kept to aid reflexivity, and highlight possible influences of the researcher in the data collection and analysis. (See for example, Appendix M). In-depth reflections are included in section 5.3, examining the research journey in more detail.

3.9 ETHICAL CONSIDERATIONS

The researcher has a responsibility to the participants and to the professional body of

EPs to conduct research in a manner which is ethical, and in accordance with professional guidance (BPS, 2009; HCPC, 2008). The BPS Code of Ethics refers to various aspects of research, including the importance of obtaining informed consent appropriately, exercising openness and honesty towards participants, and generally "consider[ing] all research from the standpoint of research participants, for the purpose of eliminating potential risks to psychological well-being, physical health, personal values, or dignity" (BPS, 2009, p.19). It is important to ensure that involvement in the research results in more benefit than harm for the participants. Ethical clearance has been gained by the appropriate bodies (see Appendix N). Details of the appropriate ethical consideration are summarised below, outlining and minimising potential harm.

Informed consent has been gained: all potential participants have been sent a participant invitation letter setting out the reason for the research; what participation involves; how the data is used, reported, stored and anonymised; what the participant might gain from involvement (an opportunity to consider the topic area in more depth, furthering their personal development); and their right not to consent, and to withdraw up until the point of transcription. The option of further questions is offered, and consent has been requested in an attached letter (Appendix G).

The above communication has been carried out via email, and only one further email prompt was been sent if the first received no response. This ensured prospective participants would not feel uncomfortable or coerced into agreeing involvement.

Confidentiality has been recognised: the audio recording of the interview was deleted immediately after the data was transcribed. The transcribers have signed a detailed agreement of confidentiality (Appendix O); transcribed data has been anonymised, using pseudonyms and omitting any place names, team names or service details which might associate the data with the participant. In transcripts, only first initials have been used. These transcripts have been kept on an encrypted memory stick for future analysis, as outlined in the participant consent letter.

The participants' names and contact details have been stored on an encrypted memory stick, and kept until a decision had been made regarding the publication of the research. In this instance, the participant would be contacted and informed that the agreed anonymising has taken place, and the details of the publication would be shared with the participant.

Risk: The use of the participants' time has been identified as potential harm, through the increased stress of adding another commitment to already busy work schedules. The impact of this has been minimised through the researcher travelling to a location convenient for each participant to conduct the interviews. It is also possible that topics relating to personal experiences of MH could be discussed, potentially causing emotional distress. In such an instance, the interview would be halted until the participant felt able to continue. Appropriate support organisations, such as a GP, or the participant's professional supervisor/senior would be suggested as an option of support, but the researcher would not break confidentiality to make a direct referral. No such situations have arisen during the data collection.

The need to avoid the participants' 'oversharing' within the interview context is outlined previously in the data collection phase.

At the end of each interview, the participant was given opportunity to ask any further questions, reminded that they could email the researcher with any concerns or queries, and informed that they will receive a summary of the research findings upon completion.

3.10 CONCLUSION

Based in a critical realist paradigm, the current study explores the constructs EPs and CPs hold of MH, and their roles in supporting this area in secondary schools. As outlined in the current chapter, the purpose of the study is to explore the participants' perspectives, therefore a qualitative design, using semi-structured interviews and TA, was adopted.

Efforts were taken to select a participant group most meaningful to the research objective, and careful consideration was given to the credibility and dependability of the

data. The researcher's role in the research journey has been explored, and steps were taken to avoid biasing the data.

The following chapter examines the findings of the data, presenting the themes in a series of thematic maps, supported by quotations directly from the participants.

CHAPTER 4: FINDINGS

This chapter reports the TA of the semi-structured interviews with EPs and CPs regarding their constructs of MH and the roles they perceive themselves and others to have in this area. The chapter is organised into three sections: the first section outlines the constructs held by EPs and CPs regarding MH; the second examines the EPs' perspectives of their own role and the role of other professionals in the area of MH; and the third section explores CPs' views of their own role and the role of other professionals in the area of MH. Quotations have been included to expand and evidence the analysis process, and the emerging themes are illustrated in thematic maps.

4.1 EDUCATIONAL PSYCHOLOGIST AND CLINICAL PSYCHOLOGIST CONSTRUCTS OF MENTAL HEALTH

This first section refers to RQ1, exploring how EPs and CPs construct MH. Their perspectives are examined separately and are then compared in a summary (section 4.13).

4.1.1 HOW DO EPS CONSTRUCT 'MH'?

Broadly, EPs adopt a social constructionist approach towards MH, expressing *caution of labels and language*, perceiving the *experience of MH difficulties as a subjective experience,* and demonstrating some *difficulties in defining MH*. These themes are illustrated in Figure 4.11 and discussed below.

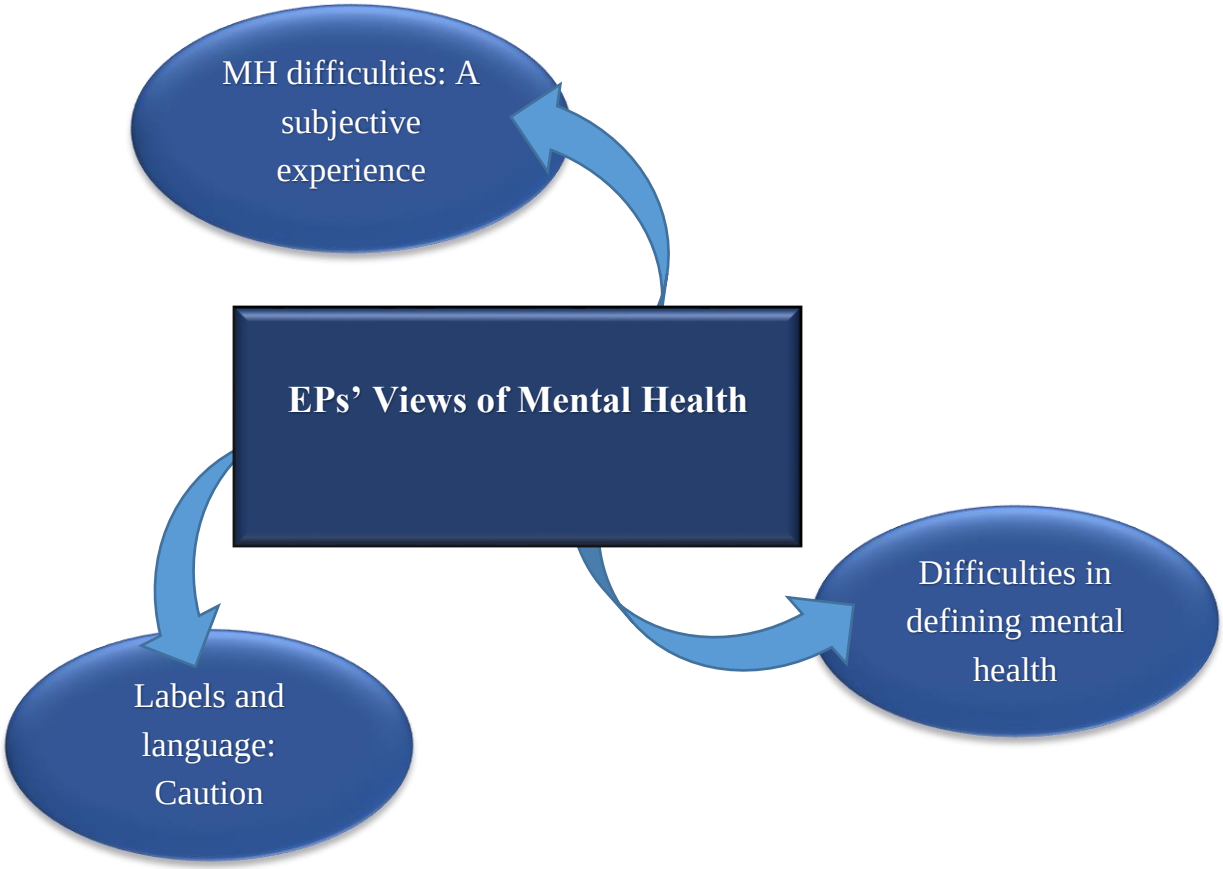

Figure 4.1.1: Thematic map of how EPs construct MH

4.1.1.1 Difficulties in defining MH

A well saturated theme is EPs' difficulties in defining MH. EPs consider the term to be potentially stigmatising, causing some avoidance of the concept: "'Mental health' it has connotations for some people. So I kind of prefer the term 'emotional wellbeing', so by saying that I am kind of saying that I think they are the same thing" (EP2, L.183-186). EPs hold no consistent distinction between EWB or MH but tend to consider themselves to be "of the emotional wellbeing cohort" (EP1, L.70), rejecting the perceived deficit language of MH, and seeking to promote a person-centred approach.

MH is too unfamiliar a term for some EPs to define: "I don't know(…) I have never worked in that high level end" (EP1, L.285-286); whereas others consider it broadly undefinable: "it is such a nebulous term that sometimes it becomes all things to all men or women and actually it becomes a bit redundant" (EP3, L.30-32). The EPs' varied constructs in this area leads to ambiguity.

Some EPs perceive MH difficulties as evident through challenging behaviours: "I think of it [MH difficulties] as behaviours that cause me concern(…) risky behaviours to themselves" (EP6, L.101-106); whereas other EPs consider MH difficulties as apparent when presentations follow a pattern, warranting medical input: "your anxieties are at a level where they- and it follows a pattern they could diagnose it" (EP1, L.122-123). Another EP identifies MH difficulties as a limitation on daily functioning and happiness: "Can you sort of do what you need to do in life in a reasonably good enough, happy and fulfilling way" (EP5 L.217-219). EPs evidently lack a unified construct of MH.

One EP claims her views around MH developed through professional and personal experience, rather than through specific training: "If I read something and then it doesn't get backed up by experience then I am not going to go for that theory so much" (EP5, L.697-699). However, other EPs refer to a range of theoretical frameworks in developing their understanding of YPs' MH needs, such as 'interactionist, ecological paradigm', 'attachment theory', or 'strong psychodynamic background'. These positions impact the ways EPs perceive MH, interwoven with their unique experiences. Perhaps unsurprisingly, there is quite a deviation in the ways that the participants felt they would identify MH difficulties.

4.1.1.2 Labels and language: Caution

EPs perceive diagnostic labels and deficit language around MH as risking constructing reductionist attitudes and stigma, remedied through normalising the concept of MH, and adjusting the language used.

Diagnoses are perceived as limiting the expectation that a child's MH could improve, and 'labels' are seen to encourage a reductionist attitude: "Once you have that label applied to you, then it's applied to you whether you are well or not…" (EP2, L.280-282). MH is viewed as changeable rather than 'fixed' as a diagnosis would imply: "This kind of spectrum of emotional wellbeing(...) at different points in our lives we might dip up and down the spectrum" (EP1, L.72-74). Reducing MH difficulties to labels is perceived to limit the anticipated recovery of the YP.

EPs consider diagnoses to be prompted by health: "Education doesn't really like talking about mental health(…) it gets all 'uppy' about it(…) and then there's the whole kind of medical model within health that likes to have its diagnoses and things" (EP5, L.599-603). However increasingly, schools are seen to seek diagnostic labels: "you have teachers coming up to you and saying, 'I am sure that child's got such-and-such'" (EP2, L.360-361). This is understood to lead to schools rescinding responsibility for supporting MH difficulties: "Their [schools'] response to that [a diagnosis] is almost one of fear and this child needs to be removed and treated and dealt with and cleansed and then possibly put back somewhere else" (EP2, L.362-365). Diagnostic labels and medical language are perceived as increasing stigma and misunderstanding.

To some extent, stigma linked to MH difficulties is perceived to be culturally constructed: "it's non-objective, it's not set in stone, so someone who talks to themselves in Kingston, Jamaica is seen as being perfectly normal" (EP3, L.53-55). In Western cultures, diagnoses appear to prompt an "us and them" attitude, allowing distance from the confusion around MH:

> When people were tidily placed in institutions you could just drive past and go, 'that's an unpleasant building, I don't want to go there', but then you have to actually come to terms with the fact that you might have somebody living close by you with a scary diagnosis (EP2, L.443-448).

EPs perceive normalising MH as helpful in reducing fear and stigma: "Mental health is for everybody, it's not just a certain sector that may have some difficulty" (EP2, L.162-164). EPs model this inclusive approach through referring to their own experiences: "I'm on the OCD end of the scale, that moves up and down(…) depending on other aspects that are going on in life" (EP1, L.126-128). MH is considered changeable throughout one's life, and seen to impact everyone. A cultural shift in perspective is seen as desirable and achievable: "I think there's quite a lot out there in terms of sort of media and education(…) education is a key factor in changing people's perceptions" (EP2, L.511-516).

However, EPs acknowledge that diagnoses have positive facets on a case by case basis: "There are people out there who are very appreciative of having a diagnosis if there's some confusion, and a diagnosis gives them clarity" (EP2, L.250-252). Furthermore, EPs appear resigned to the fact that diagnoses sometimes provide access to services: "I

might consider [the system] to be flawed but it's there nonetheless and that individual, that person, has to operate within that system, so, for example, diagnostic criteria carry a lot of power in the health related professions" (EP3, 220-224).

It is evident, that through maintaining a focus on the YP and avoiding reductionist attitudes, EPs consider diagnoses to be viable.

4.1.1.3 MH difficulties: A subjective experience

Another well saturated theme is the view that experiences of MH difficulties are variable and subjective, with a range of external and internal factors impacting on both the development of a difficulty and the recovery: "there can be genetic components, can be developmental components, can be physiological biological components" (EP3, L.145-147); "there is a genetic nature/nurture interplay and nurture has quite a high influence on whether the genetic switch gets flicked or not" (EP4, L.272-274).

Subjective environmental experiences are perceived to either support or challenge MH. A sense of connectedness is considered an important protective factor: "[if] you look at how the community can relate, and the family can relate, to individuals then it can have a huge impact on how happy that person is" (EP3, L.125-127). Whereas, less positive external factors, such as familiarity with self-harm is considered a risk factor: "I worry that it's [self-harm] something more because it's out there and young people talk about it. I sometimes wonder if there's a bit of copycat factor…" (EP6, L.129-131).

Furthermore, there is a perception that if MH difficulties develop, the YP's presenting behaviours may interact with the environment to create a maintaining cycle: "…impacts their ability to access curriculum, form and sustain friendships and relationships with others and behave in a way that has an adverse [impact]" (EP4, L.126-128). Positive engagement is considered an important aspect of recovery.

The *impact* of MH difficulties is also perceived to be subjective: "All of us have their level, and it's about how much it intrudes upon our life, and what barriers does it present to us" (EP5, L.210-212). The YP's perspective is therefore seen as essential in developing an understanding of need: "I always try to imagine myself if you were having those thoughts(…) 'I get really anxious when I am in a small space' what would

that be like(…) for that person, and try to see the world from their point of view" (EP3, L.175-180).

The YP's own resources and resilience are considered essential in managing MH, impacting the subjective experience: "people haven't perhaps got that insight or wish to get better or to feel more well about themselves or even to recognise that they are in a particularly poor state…" (EP1, L.165-168). A desire for recovery is considered an important first step; followed by an awareness of their own needs, and strategies to manage their specific experience: "a greater understanding and awareness of our own - what we can do ourselves and how we can support each other, should definitely reduce that [MH difficulties]" (EP2, L.553-555). The ability to reflect and create space to connect to other people is considered important in the process of recovery.

Recovery is not seen as a finite, objective experience, rather an ongoing movement on the scale of MH through recognising what subjectively helps: "I think that promoting mental wellbeing(…) I think it's essential" (EP6, L.153-154). Acknowledging environmental factors of influence and the subjective impact of MH difficulties is considered helpful in achieving this.

These perspectives are summarised and compared with the views held by CPs at the end of section 4.1.

4.1.2 HOW DO CPS CONSTRUCT 'MH'?

CP perceptions of MH are grouped into four over-arching themes. MH is seen as *enduring emotional distress*, conceptualised within a *developmental framework.* Whilst CPs acknowledge *tensions in categorising* MH difficulties, it emerges that they are *confident with the concept* of MH.

These themes, as illustrated in the thematic map below, are explored in more detail.

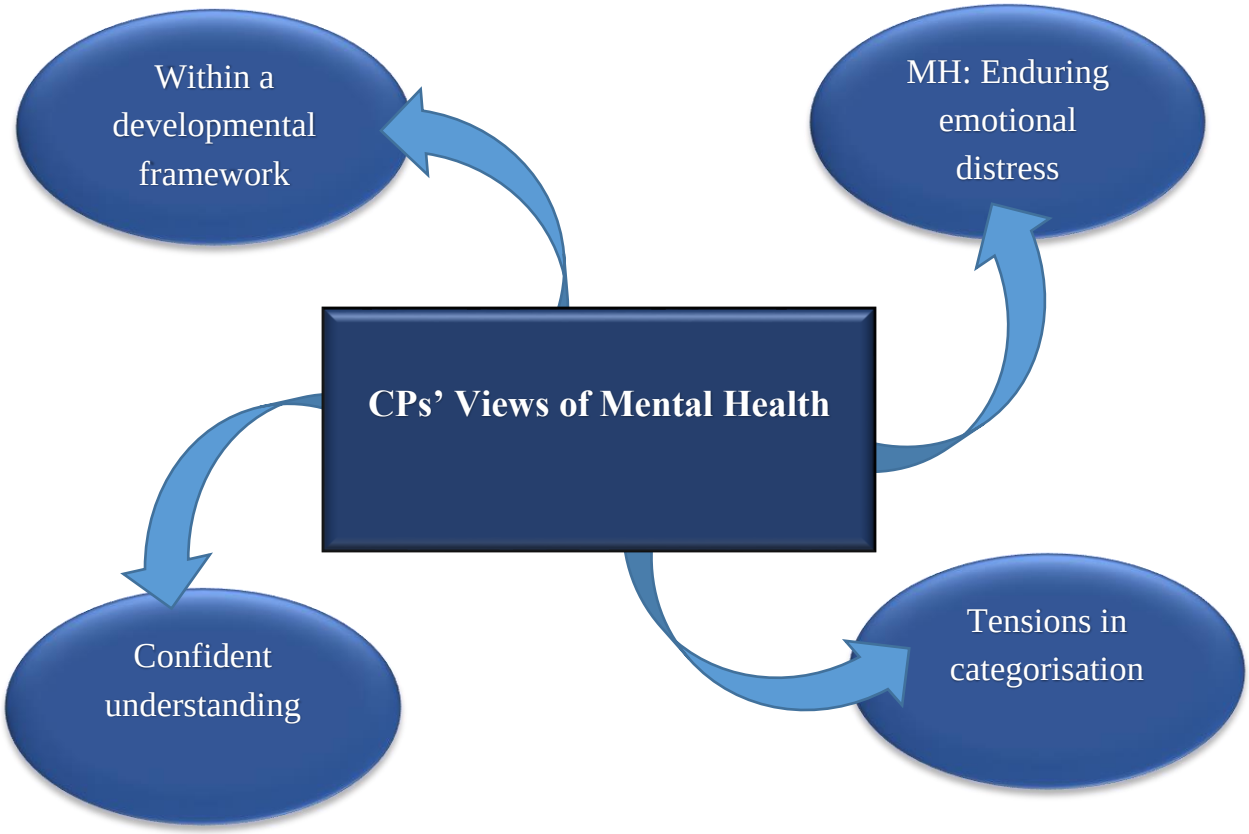

Figure 4.1.2: Thematic map of how CPs construct MH

4.1.2.1 Within a developmental framework

CPs perceive a developmental framework as important in conceptualising MH, acknowledging the developmental stage of adolescence as having both an environmental and neurological impact on MH.

Adolescence is understood to be a particularly vulnerable period for developing MH difficulties: "15 to 24 year olds probably are the peak period for people to develop that kind of(…) difficulty [self-harming behaviours]" (CP1, L.774-776). The interaction of neurological changes and environmental factors is considered significant: "I view both psychosis and personality disorder in terms of the developmental trajectory of the person and the impact of their environment during development of their mind really" (CP2, L.252-255). Developmentally, significant changes occur during adolescence, impacting on MH.

Difficult emotions are considered typical of adolescence: "Worry, insecurity, erm avoidance(…) it's almost a normal experience of adolescence" (CP2, L.440-441), and

the challenge is identifying when these emotions have become enduring and problematic:

> The remit of what is regarded as wellbeing for a young person is-is less than it is as an adult(…) if you measured that person in terms of their mental health in one context, would be seen as ok, but you change those variables in terms of their age or the-they pressure of soc-, it would be seen as not well. (CP6, L.235-240)

There appears to be a cultural spotlight on adolescent MH. It is perceived not only as a period of increased vulnerability, but also increased likelihood of recovery: "there's definitely a drive to treat it [eating disorders] and the evidence suggests that if they weight restore within the first year, they have got a 75% chance of them never having it again" (CP1, L.667-670).

During adolescence, attachments are considered an important protective factor, building resilience and emotional intelligence: CPs consider attachment theory in developing an understanding of MH.

> If you have a decent attachment then you are much more likely to have erm to function better generally in life because that shapes, our experiences shape our brain, they shape erm, our central nervous system, it shapes our emotional regulation, it shapes everything. (CP5, L.93-97)

Parental figures and secure attachments are considered significant in promoting MH or MH difficulties developing: "people shouting and being horrible to their children(…) certain basic things that can be really damaging" (CP5, L.275-277). Secure attachments are considered protective factors for YPs and, when absent, reduce their capacity to develop emotional intelligence: "[if they've] never had the opportunity to make sense as to what their feelings are(…) then how are they going to think about it and then verbalise it?" (CP5, L.271-273). Working with the family is therefore considered important in reducing the potential of MH difficulties: "just by helping the parents become more in tune with their child: 'when they do this, this is what they actually are experiencing', you are doing that preventative work" (CP5, L.342-344).

Other aspects of the adolescent stage of development are acknowledged by CPs. Building resilience and emotional intelligence is understood to support adolescent MH, as developmentally they are growing in autonomy: "Resilience building(…) is a big issue(…) so you're building those scaffolding bricks right the way through(…) you

know, *keeping yourself well, recognising stress,* and is a really important thing" (CP6, L.405-409); adolescent attachment figures are increasingly peers, rather than family: "Particularly when you are working with young people(…), it often means that you are involving other young people" (CP3, L.317-319); and adolescents are heavily impacted by both their relationships and their environment: "they [YPs] are so much more entwined in terms of the context in which they're expected to live in, and I think there is less flexibility for a young person" (CP6, L.233-235). CPs perceive these factors as important when conceptualising MH in YPs.

4.1.2.2 MH: Enduring emotional distress

A well saturated theme suggests that MH difficulties are emotional distress at a level of endurance and risk which is detrimental for the individual: "People that are severely distressed, for whatever reason and that can show itself in lots of different ways, from sort of psychosis to very, very low mood to suicidal thinking and attempts" (CP3, L.173-176). YPs experiencing MH difficulties have reduced capacity to manage challenging emotions: "[A] sort of reduction in erm what we could call, erm, psychological flexibility(…) I mean the ability to be resilient in the face of stresses" (CP2, L.170-173).

However, emotional distress in response to a one-off reaction to a traumatic event is not considered a MH difficulty:

> If something happens to someone, and they have a reaction to what's happened – it's kind of very easy to pathologise(…) and actually, it's kind of within a context that's explainable and maybe with time they'll kind of move out of that. (CP4, L.152-156)

Only enduring distress is considered a MH difficulty. Some YPs may display some level of emotional distress but cope quite well, this is not considered a MH difficulty: "there is a difference between somebody's behaviours and how they are coping emotionally. So you do have children that self-harm but they are not necessarily mentally unwell by self-harming" (CP1, L.703-706). This distinction could be identified through their capacity to function: "There are lots of people out there that have OCD, undiagnosed OCD, undiagnosed anxieties or stuff would probably(…) meet criteria, but actually it doesn't get in the way of their daily living…" (CP5, L.114-117). Emotional

distress which does not significantly impact their wellbeing is not considered a MH difficulty.

Considering the function of a presentation might highlight whether it is in an enduring MH difficulty: "I start trashing my room and throwing things, breaking things then they stop arguing, they come and shout at me, but at least I feel confident that they [mum and dad] are not going to split up" (CP2, L.514-517). In such a scenario the distressed behaviour is objectively logical, possibly suggesting that there is no MH difficulty.

Failing to recognise what is being communicated through the emotional distress could limit the potential to support the YP. Examples are given: "they might wake up [from an overdose] and think, 'Well, that worked, I've got everybody around the bed, the boyfriend is back with me'" (CP1, L.726-727);

> Or you might fall into it [an eating disorder] because of sexual abuse or some kind of traumatic incident and it's your way of managing that(…) actually not eating does protect you from those negative, horrible feelings, and when you start eating again, you are then exposed to them. (CP1, L.638-643)

Interpreting the emotional distress provides insight into the MH difficulty.

4.1.2.3 Tensions in categorisation

CPs acknowledge the tension between services needing to measure the effectiveness of MH interventions: holding the view that MH difficulties are fluid, sometimes socially constructed, impacted by a range of interacting factors, and difficult to categorise.

MH difficulties are seen as existing on a continuum: "those experiences [personality disorders and psychosis] also exist on that same spectrum, erm, so it's more helpful to think of psychosis perhaps in terms of a number of kind of different symptom groups that exist on spectrums" (CP2, L.239-241). One's position on the MH continuum is seen to shift: "We move up and down, everyone moves up and down(…) we all have feelings and emotions and levels of distress" (CP5, L.141-147); and it is considered very difficult to determine "at what point you say someone's got a mental health difficulty or problem, and somebody else hasn't, it's probably a very, very grey area" (CP3, L.211-213). As the individual's MH is understood to fluctuate, "hard and fast lines around

mental health to say what it is and what it isn't" (CP2, L.133-134) are treated with caution.

Cultural expectations are seen as influencing the potential for a diagnosis:

> The same presentation of symptoms in Africa maybe would be seen as a gift and would be revered and would be something that people aspired to, whereas over here we would say it was psychosis and they were delusional and we might lock them up. (CP1, L.1006-1010)

One CP implies that Western culture requires diagnoses to make sense of troubling behaviours: "The general public like to think that they are, you either have a mental health problem or you don't and that's where the stigma comes from(…) it's in group, out group social psychology" (CP5, L.156-164). Labels allow people to distance themselves: "a diagnosis means the family kind of ta-take even a further step back(…) it gives them kind of permission not to try and kind of make things better…" (CP4, L.291-297). Furthermore, MH diagnoses may just be a reflection of the systems around a YP: "often they themselves [YPs] aren't presenting with the problem, often it's *others* around them saying that the young person has a problem, or is-is-is problematic often to *them*" (CP6, L.183-186). Society appreciates diagnoses simplifying complex, messy difficulties.

A further concern suggests professionals adopt the reductionist nature of diagnoses, hindering "[their] creativity and the thinking" (CP2, L.403-404). A diagnosis was seen as failing to capture the complexities of an individual's experience: "'This works well for anxiety' or 'this works well for depression', and so people then kind of think, 'Oh, there's a depressed person, we'll do that'" (CP3, L.151-154); "If you have got ten people lined up with depression, they have all got it for very different reasons, and they are all completely different people" (CP5, L.203-205). Diagnoses risk losing important detail about the individual and their experience of MH.

However, CPs acknowledge that "diagnoses do help us to organise our thinking, they do help us to communicate(…) a lot of ideas very quickly" (CP2, L.395-398). Furthermore, a diagnosis communicated well "simplifies things for them [the family](…) it can be very validating. It's a good way of describing things" (CP3, L.358-360). When treated with caution, diagnoses and categorisations of MH difficulties are considered beneficial.

A final tension observed is the pressure on MH services to evidence the effectiveness of their practice: "it's [MH services] the one bit of the health service that you can get away with cutting" (CP1, L.494-495). It is necessary to evidence outcomes to validate MH services. Furthermore, services cannot be accessed without labels to communicate distinct categories of need: "I would say it's [MH] a continuum, but umm mental health services have always been set up and commissioned for people who are mentally unwell" (CP1, L.423-425). Whilst CPs perceive MH difficulties to be complex and multifaceted, pragmatically, they consider it unrealistic to avoid diagnoses and categorisations entirely.

4.1.2.4 Confident understanding

This final theme emerges through CPs' capacity to articulate their constructs of MH based on experience and training.

CPs feel confident in the support they offer around MH, referring to concrete examples of MH presentations, for example: "but again, quite often it's [psychosis] trauma driven" (CP1, L.776);

> …or the adolescent who finds themselves drawn to continually checking the locks(…) what I am doing here is thinking about(…) the symptomatic markers of diagnoses of anxiety disorders, such as agoraphobia, obsessive compulsive disorder and I am using that to help me be attuned to the young people whose sort of worries are normal worries and insecurities and avoidance might be getting to a level where it's impacting on their life. (CP2, L.447-456)

There is a clarity in the formulation of MH difficulties.

Some CP participants in the current study, have chosen to work outside of the NHS, "being able to step out of what was a traditional mental health service, and have the flexibility to think more 'psychologically'(…) finding like-minded individuals and psychologists" (CP6, L.286-303). A confidence in their own perceptions of MH is evident.

A slightly less saturated, but evident sub-theme, highlights CPs connecting personally with MH: "feeling scared, feeling lonely, feeling outside(…) touched for me a lot of my memories(…) similar feelings of being on the outside and struggling to work out how I

fit into my environment" (CP2, L.318-324). Drawing on personal experiences enriches an understanding of MH.

Finally, a confidence in the training they had received is communicated: "obviously my teaching there [at university] shaped how I viewed(…) the kind of theoretical models which I hadn't really known about before, about depression, anxiety and all of that kind of stuff" (CP1, L.955-957). Frameworks and theoretical understandings are applied throughout the perspectives shared by the CPs.

4.1.3 Summary of EP and CP constructs of MH

EPs communicate a variety of understandings of MH, shaped through their experiences and theoretical frameworks. MH difficulties are understood to be a subjective experience, emerging through complex interplay of internal and external factors. Similarly, CPs acknowledge the many interacting factors impacting MH, but apply a developmental framework to their understanding, defining MH difficulties as enduring emotional distress.

EPs appear reticent in discussing MH difficulty, partly as it is an unfamiliar construct. CPs, however, evidence a greater confidence in incorporating MH difficulties into their construct of MH, demonstrating applied theoretical understanding in this area.

EPs consider diagnostic labels and deficit MH language potentially to cause stigma and increase culture's disengagement with MH. CPs also express concern around diagnoses, but perceive professionals' adopting a reductionist approach to be a greater risk than possible stigma. Both EPs and CPs acknowledge that diagnoses support access to services and may progress understanding for the YP.

4.2 Educational Psychologists' views of professionals' roles in supporting the Mental Health of secondary school aged YP

This section considers EPs' perspectives of their own role (referring to RQ2) and the perceived role of other professionals (referring to RQ3) in supporting the MH of secondary school aged YP, as summarised in Fig 4.2. First, the EPs' understanding of their own role is examined, followed by an overview of their perceived role of both CPs

and other professionals. A comparison between these views, and the views held by CPs is presented at the end of the chapter (section 4.4), providing a response to RQ3.

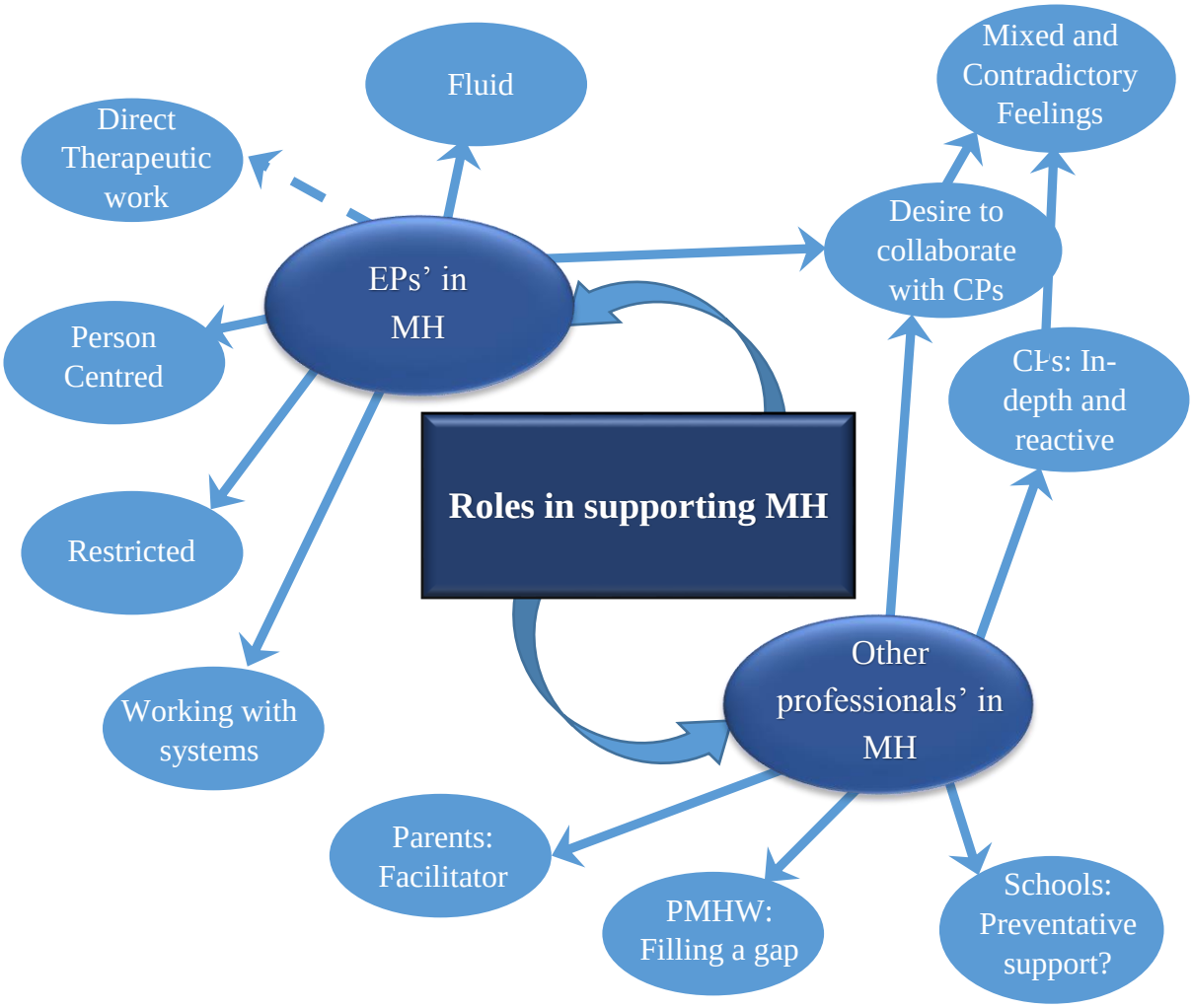

Figure 4.2: Thematic Map of EPs' views of professionals' roles in supporting MH

4.2.1 How do EPs perceive their role in the area of MH in secondary schools?

Four over-arching themes emerge regarding EPs' perceptions of their role: *fluid*; in some respects, *restricted*; *working with systems* around the YP; and maintaining a *person centred approach*. The less saturated theme, providing *direct therapeutic work* for the YP, emerges as a slight anomaly, contradictory to the other main concepts, hence was treated with caution (represented in Fig 4.2 with a dotted line). These themes are discussed below.

4.2.1.1 Fluid

This well saturated theme emerges from EPs perceiving themselves to work with a variety of systems, filling the gaps left by other services, and progressing their skills accordingly. This approach to working is seen as necessary and positive.

EPs see their engagement at different systems levels as a strength:

> The best Ed Psychs I have ever met actually are able to operate almost like seamlessly move between those systems and actually think at different systemic levels erm and I think that's probably about the most powerful thing they can actually do. (EP3, L.346-350)

When other services are considered under-resourced and inaccessible, EPs see themselves as filling gaps: "Children have to have a very high threshold of need in which to access those services [CAMHS], so sometimes things are brought to us, because the other services seem inaccessible" (EP2, L.825-829). EPs demonstrate a willingness to offer a service to meet the YPs' needs, even if it is not their area of expertise: "I said to the parents, well they [CAMHS] are not going to pick up the individual work with him, would you mind if I tried and I actually did some?" (EP3, L.702-704). This flexible attitude leads to an increasing range of approaches.

This need to fill gaps is seen as an opportunity for EPs to develop new skills: "I think it's important to work like this: 'currently I don't have the skills to do it, how do I get them'" (EP3, L.532-534). However, concern is expressed that *some* EPs might find it easier to dismiss unfamiliar areas rather than pursue them, limiting their potential: "it's easier to dismiss it and much harder to try, so, erm, yep, EPs by all means can actually do CBT training" (EP3, L.504-505). If the correct training is sought, nothing is considered off limits within the EP role of supporting MH.

However, limits are acknowledged: "we are meant to know a little about an awful lot(…) which is hard" (EP1, L.813-814). The ever increasing remit for EPs may lead to the profession feeling stretched and lacking depth, suggesting a limit to the extent of fluidity and gap plugging that can be maintained.

4.2.1.2 Restricted

In contrast with the optimism of the above theme, are the restrictions felt by EPs: EP services have limited resources, and may lack the appropriate training to support MH difficulties. Furthermore, confusion amongst other professionals around the EPs' role is seen to restrict the variety of work EPs can engage in.

Although EPs are willing, limited resources in the LA have led to a service delivery model which does not allow the necessary time commitment for direct work, and "if you are an educational psychologist delivering therapy interventions you don't necessarily get any supervision around it" (EP5, L.1506-1508), a necessary aspect of safe therapeutic practice. Squeezed EP resources has led to reduced opportunities for preventative approaches to MH: "we haven't had planning meetings for a couple of years, so they [schools] can only refer for precise things" (EP5, L.1065-1067). A deficit focus is inadvertently being encouraged, rather than shifting to a whole school ethos of promoting MH. Meanwhile schools are becoming increasingly focused on academic performance, reducing their capacity to prioritise MH initiatives: "I don't think it's [emotional wellbeing] at the forefront of most schools. I think in most schools it's around the academic achievement of children and getting the best so that they get good OFSTEDs" (EP1, L.510-513).

The EP skill set is raised as another possible restriction: whilst one EP maintains that most skills could be learnt, others acknowledge limited capacity: "If an individual has a difficulty or disorder that requires medication(…), that's not our remit, erm and I think if a young person is posing a risk to themselves or other people, then that's not our remit" (EP1, L.474-478). There is an uncertainty around when MH becomes a medical issue, and what role EPs could play in MH assessment.

A final restriction in the EP's capacity to support MH, is others' confusion about the EP role:

> I am not sure how schools perceive us, some schools(…) do have quite a traditional view of the role of the educational psychologist, and may think much more in terms of sort of learning in cognition and less about emotional being. (EP2, L.845-850)

Promoting MH is seen as a relevant aspect of the EP role. However, this is limited through mismatched expectations. It is suggested that EPs must promote themselves: "it's building my own tools, believing in what I do and then talking about that(…), noticing where it can be used in these other situations" (EP4, L.582-584): making schools and other professionals *aware* of their skill set to avoid these restrictions.

4.2.1.3 Working with systems

Another highly saturated theme is EPs *working with systems* around the YP, offering whole school preventative approaches to MH, involvement with families, and collaborative information sharing, bringing the different systems together.

EPs suggest that their relationships with schools promotes whole school change: staff highlight specific concerns, and over time the EP can develop a meta-perspective of the schools' needs.

> I go into schools where there is actually a lot of staff illness, turnover and those kind of things, so actually that's more of a problem impacting on children later on. I think it's working more with the adults around the children would be erm, one way I think our service could help. (EP4, L.494-498)

EPs are well informed within the school system, yet distant enough to see the bigger picture: "What we bring is clarity and objectivity because you are coming in. Once you are in it, you cannot see the wood for the trees" (EP6, L.315-316). Training schools in specific approaches (for example, Mindfulness) is considered effective for promoting staff wellbeing, enhancing YPs' readiness to learn, and equipping staff in managing low-level MH needs:

> Children that we work with often come from fairly traumatic communities and family situations(…) If you could just slow things down and actually take a breath with them and get them to think about the present rather than where they have just come from… (EP3, L.571-577)

Assisting schools in planning is also perceived as useful in equipping systems around the YP: "…help schools work out their systems, so what do they do? How do they notice, and when they notice, umm young people, you know, it's distress, what do they do about it?" (EP5, L.915-918).

A less saturated subtheme is EPs supporting the families of YPs experiencing MH difficulties, through weekly parenting groups or through supporting parents to navigate the system. This will be explored in more detail in the following theme.

To some extent EPs feel able to operate as a bridge between schools, family and health, sharing information, sign posting and working collaboratively: "I might be the first port of call that they says, 'yes, that's looking like a diagnosable condition and I think as part of my advice I would be then referring on to CAMHS" (EP4, L.226-229). Triangulating information with health provides a greater insight into the need: "They [CPs] may have had more contact with the family than I might have had, or I might have had more contact with the school and the child and how they are in that context(…) pooling that" (EP2, L.1115-1120). EPs feel that bringing systems together is an important aspect of their role.

4.2.1.4 Person centred

This theme highlights the EPs' focus on the YP. By seeking to understand the YP's perspectives, ensuring that the family's needs are being met, and maintaining a holistic view of the YP, the EP is an advocate for the family, whilst considering the long term outcomes at each stage.

Listening to a YP, using a strengths based approach is at the core of the person centred work: "she is articulate, she is thoroughly pleasant, she is musical, she is obviously not unintelligent, erm but often the day will be a struggle and she has very very dark times" (EP6, L.544-546); "the young person is key. They're the person I listen to most(…) that's the most crucial bit of information" (EP5, L.804-808). Maintaining a clear view of the YP rather than "the problem" is considered important.

Through a holistic approach to information gathering, drawing on the YP's strengths and insights, EPs maintain a positive, future orientated perspective: "the world is not going to stop spinning because of it [a MH difficulty], there are things that we can do, let's move beyond the label, let's think about the solutions" (EP3, L.296-299). Focusing on what the YP needs to function well provides a framework for EPs supporting MH.

EPs have a role in supporting the family through making professional practice accessible to them: "educational psychologists who are very used to, umm, stating things neatly and clearly, transparently" (EP5, L.1389-1391), and through supporting parents when they feel ill-equipped: "I could see she [the mother] was nervous, so I said to her, 'why don't you introduce yourself and if you would like, I'll speak to him or her [the youth justice practitioner] on the phone [to chase up a parental request]" (EP6, L.229-231). EPs perceive themselves to be advocates for the family and YP.

4.2.1.5 Direct therapeutic work

This theme emerges from only two of the participants' accounts, possibly because most EPs are not resourced to do therapeutic work. Direct therapeutic work by EPs focuses on building resilience and promoting MH, or working with the YP to identify solutions and future plans: "I could potentially offer 1 to 1 solution focused brief therapy since I am trained in that" (EP5, L.814-815). Only one EP refers to the possibility of using CBT with YPs.

4.2.2 HOW DO EPS PERCEIVE THE ROLE OF OTHER PROFESSIONALS IN SUPPORTING MH IN SECONDARY SCHOOLS?

When considering other professionals' roles, it emerges that EPs perceive CPs as having a *reactive yet in-depth role*, and are interested in *collaborative working with CPs*. Perspectives within these two themes are slightly *mixed and contradictory* – a further theme which will be examined. It also emerges that *schools could offer preventative support.* EPs consider both PMHWs and parents to hold specific roles of filling the gap and facilitators, respectively. A detailed explanation of these themes is below.

4.2.2.1 CPs: In-depth and reactive work

EPs consider CPs to provide a highly specialist service, causing the thresholds for involvement to be narrow, and systemic or preventative work to be limited. To some extent, EPs consider the in-depth work to be valuable: "in terms of the specific therapeutic intervention, a psychologist who has been trained in supporting children with obsessive issues might have more impact" (EP2, L.679-682), particularly when it

is perceived to be beyond the EP capacity: “the therapeutic work I can’t do(…) that to me is their role and any diagnosing” (EP4, L.678-681).

However, there is a concern that CP thresholds will become dangerously high as only a few YPs can receive in-depth support: “[health will] make the referral pathway criteria so high that no-one’s ever going to get there unless they kill themselves in your office” (EP3, L.918-920). A consultation approach is suggested as a possibility for extending resources: “actually try and disseminate in a consultative way” (EP3, L.915-916).

CPs tend to become involved “when something has gone wrong and there is a difficulty” (EP2, L.970-971), potentially adopting a deficit model: “I think they can be a little too looking within the child(…) they get caught up in the processes” (EP5, L.1255-1482). Anecdotes are shared of CPs discharging YPs who do not engage, regardless of their need: “because he [the YP] wasn’t able to engage in the therapy she [the CP] was offering, she didn’t see him anymore” (EP2, L.687-688). Evidently EPs feel changes need to be made to the CP service delivery model.

4.2.2.2 Mixed and contradictory feelings

EP perspectives of the CP role appear based on specific experiences and anecdotes, seemingly leading to contradictions and mixed views. For example, CPs are considered *unwilling* to work flexibly, insisting on tight thresholds, and failing to offer a child-centred service:

> I do know(…) that it [working in the community] frightens them [CPs]. Again, there is a lot of lip service in clinical psychology around community working(…) when they look at it, they sometimes back away and they use things like results as there aren’t enough of us, we just can’t meet capacity, we can’t do it(…) but actually, I think there is something about actually defensive practice and professional territoriality (EP3, L.879-886).

Although most CP work is considered very narrow, one CP is mentioned and praised for using a more consultation based approach: “rather than sitting in an office, he is out there(…) he is touching a lot of people” (EP3, L.946-948)

A concern emerges that CPs do not communicate effectively with other systems around the YP, particularly schools: “they [schools] actually want very, very practical stuff,

whereas I think clinical psychologists think that they mean some sort of much more deep and meaningful stuff" (EP5, L.1338-1340). Contrasting expectations and poor communication appears to impact effective working between systems. EPs find that schools feel CPs should share with them more: "The school felt very out of the loop because they hadn't been kept up to date with worrying issues around suicidal intent which the school felt they should know about" (EP2, L.1030-1033). CPs are seen as a valuable source of recommendations and insight for the staff members, but this input is perceived not to be forthcoming.

However, it is suggested that CPs might see liaising with schools to be the EPs' role: "I don't think they have done any kind of work with the school around strategies to manage or to support that particular aspect of difficulty(…) I think they probably see that as our role" (EP1, L.800-803), and potentially CPs cannot provide schools with the content of therapeutic work: "Schools need to understand that it is completely inappropriate for the clinical psychologist to share what's going on in therapy, unless it's the young person wants them to share it. So it's all of those boundaries" (EP5, L.1363-1367). To some extent, the in-depth, therapeutic nature of CP work limits the potential for supporting change in the systems around the YP.

4.2.2.3 Desire to collaborate with CPs

EPs perceive collaborative working with CPs as providing mutually better services. For example: "You [EPs] need to have clinical supervision if you are doing some kind of therapy. So ideally, wouldn't it be wonderful if clinicals and educationals could work more closely together and kind of help fill in each other's gaps" (EP5, L.1527-1531). Furthermore, combining information gathered by CPs in a clinical setting and EPs from the school setting is seen to enrich formulation: "checking our hypotheses against each other. Erm, we give them an insight into that child beyond the clinical room" (EP6, L.880-882).

However, joint-working is considered hard to achieve as there are not enough CPs, and it is difficult to coordinate communications: "Sometimes it feels like one way traffic; sometimes it feels like we are getting, trying to get ahold of them [CPs], they are not necessarily getting ahold of us…" (EP6, L.852-854). CPs seem inaccessible to EPs,

possibly due to a lack of resources, but perhaps as "each other's aims are very different" (EP5, L.1384-1385).

> I think that our roles could be very enmeshed but they tend not to be, and it's all around things like capacity and time and location and ummm perceptions of different role, not wanting to sort of tread on each other's toes. (EP2, L.1127-1131)

A greater clarity around roles and purpose is seen as important, although it emerges that: "we just bury our heads and get on with our own little jobs" (EP2, L.1215-1216). It is hypothesised that clearer communication and possibly shared training, would be beneficial.

> "It's more about the understanding. Not of each other's roles but of the work. So if Educational Psychologists had a bit more of a clinical background, and the clinicals had a bit more of an educational background, I think that would benefit the young people" (EP5, L.1586-1591).

A greater cohesion between the services is perceived as beneficial for the YP receiving support for MH.

4.2.2.4 Schools: Preventative support?

EPs perceive schools as well positioned to promote MH for YPs. Schools can utilise the curriculum to enable "children emotionally and socially to develop all their skills" (EP1, L.644-645); and create an environment which promotes wellness: "If we are really going to address the mental health issues of the young people, we have got to look at the systems around them" (EP4, L.670-672). One participant suggests that teachers should recognise their own MH needs so they can be emotionally available for the students, modelling methods of improving wellness.

There is a perception that teachers should provide a safe base for YPs: "Just saying 'hello' and just being nice, just being friendly, doesn't take an awful lot of training, and that can make a huge difference" (EP2, L.877-879). Developing a relationship is seen as beneficial: "if you don't form a positive relationship with that student, it doesn't matter what you teach them, they are not going to learn a thing(…) for me, everything is about the relationship" (EP4, L.627-629). A nurturing school environment is seen as conducive to effective learning and good MH.

Teachers are seen as having potential insight into changes in behaviour and presentation: "if they [teachers] ask themselves, 'what is this young person trying to tell me through their behaviour, and being a bit curious about it, rather than just you know, dismissing and sending them out…" (EP5, L.1175-1178). Helpful responses are identified as teachers gathering information from colleagues, referring concerns to the pastoral support team, or signposting the YP to services. However, adopting a purely behavioural approach, or teachers considering MH to be outside of their remit, are identified as hindrances to the preventative support schools could offer.

Anecdotally, schools are considered to vary in their willingness to engage with matters of MH.

> I could have two schools(…) one set of teachers would say, 'yes, this [pastoral care] is definitely part of my role as a teacher(…) you go to another school and they say, 'I teach French, I teach maths, I teach English and I don't do that – that's your job, thank you very much'". (EP3, L.791-799)

Some schools are seen as wanting MH to be dealt with away from the school environment, not "recognising that actually they could be emotionally young healthy young people, even if they did have those difficulties" (EP1, L.677-679), thus compromising the protective environment school *could* be. However schools might be incentivised to engage in preventative initiatives: "if you [the EP] says, 'if we all do this, he actually might learn better', schools go, 'yeah ok, we'll buy into it'" (EP3, L.843-845).

Schools are sometimes seen as *willing* to support but lacking resources, training, or knowledge. "If you have a child coming in to school who's already got a recognised mental health issue, I think it's very important that the people who work with that young person are briefed" (EP6, L.766-768). Poor communication between schools and other services is considered detrimental in providing support for the YP. Furthermore, there is a lack of training around MH in teaching qualifications, and policy guidelines are seen as inaccessible:

> There's an awful lot of things that are sent to schools, and schools have said 'read this update on blah, blah, blah and emotional wellbeing in schools' and I am not sure necessarily that even the best of them to read it all. (EP1, L.503-506)

Whilst schools are theoretically well positioned to offer preventative MH support, EPs suggest that they need more support.

4.2.2.5 Parents: Facilitators

Although the participants in the current study were not specifically asked to consider the role of the parent, parents are referred to as facilitating access to services: "the stumbling blocks in, you know like, if the family don't turn up for a therapy session for instance" (EP4, L.770-772). The family is considered the gatekeeper to the YP, and the home environment understood to have a significant impact.

4.2.2.6 PMHW: Filling a gap

Similarly, the role of PMHW was mentioned spontaneously, broadly perceived to be a positive health presence in schools, facilitating opportunities for joint working. However, it was suggested that PMHWs fill a gap left by the lack of CPs: "they [PMHWs] do amazing stuff and I have absolute respect for them, but I think when you're employing lots of them and less psychologists, I think you are dumbing down the profession" (EP5, L.1543-1546). Uncertainty around the PMHWs' fitness for purpose is evident.

4.3 CLINICAL PSYCHOLOGISTS' VIEWS OF PROFESSIONALS' ROLES IN SUPPORTING THE MENTAL HEALTH OF SECONDARY SCHOOL AGED YP

This section considers CPs' perspectives of their own role (referring to RQ2), and the role of other professionals (referring to RQ3) in supporting the MH of secondary school aged YPs, summarised in Fig 4.3. First, the CPs' understanding of their own role is examined, followed by their perceived role of the EP and other professionals. A comparison between these views, and the views held by EPs is presented at the end of the chapter (section 4.4), providing a response to RQ3.

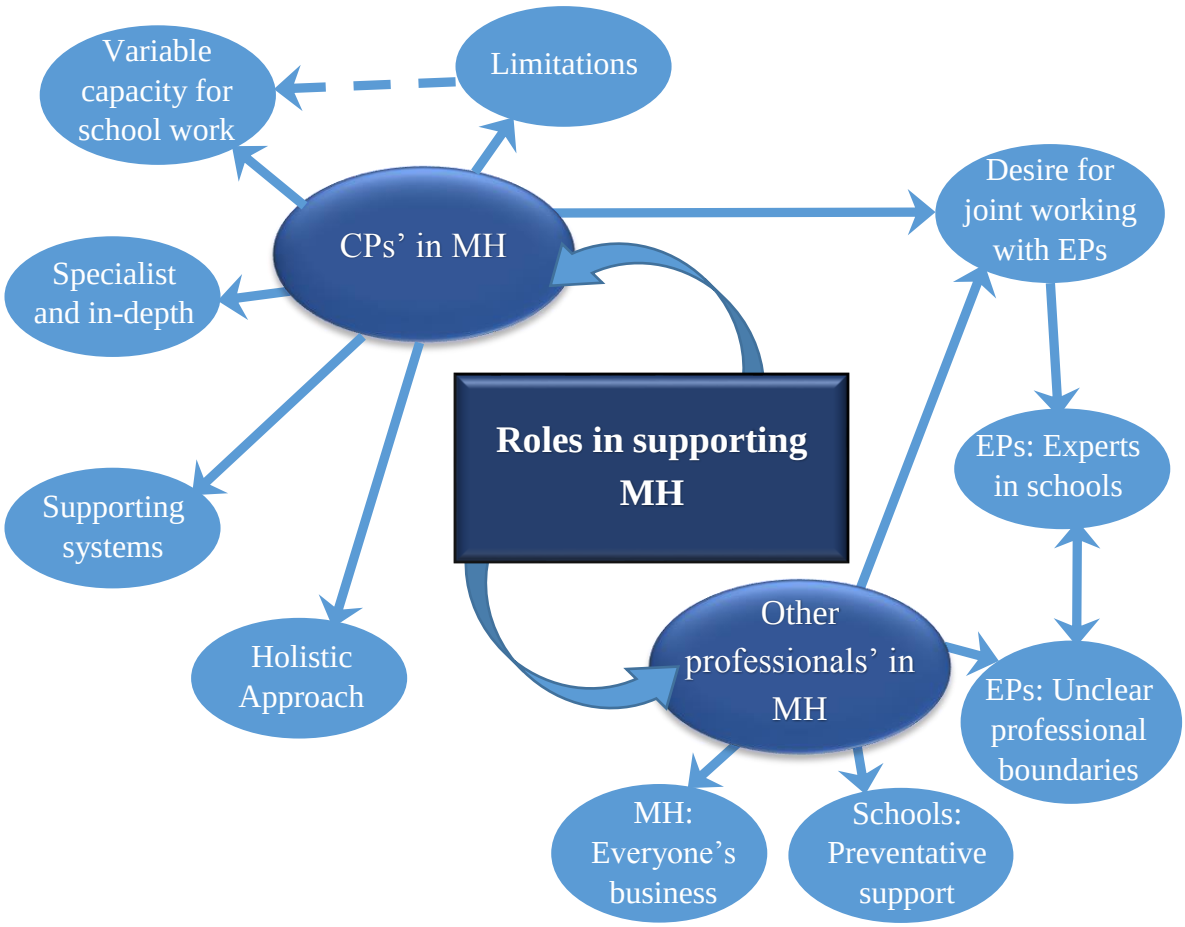

Figure 4.3: Thematic map of CPs' views of professionals' roles in supporting MH

4.3.1 How do CPs perceive their role in the area of MH in secondary schools?

Five themes emerge through the analysis of how CPs see their role in MH: taking a *holistic approach* to supporting the YP; supporting change within the *systems*; and providing *specialist, in-depth interventions*. The CPs acknowledge the *limitations* of their role; and it emerges that they vary in their perceived *capacity for school work.* Limitations in resources partly explain the varied approaches to working with schools, hence the latter two themes are linked with a dotted line in the thematic map (Fig 4.3). These overarching themes are discussed below.

4.3.1.1 Holistic approach

CPs adopt a holistic approach to supporting YPs. Reference is made to listening to the subjective experience of the YP, gathering information from a breadth of sources, and avoiding being restricted by a diagnostic label.

CPs consider themselves able to develop a relationship with the YP and others involved, in order to have mutually honest and meaningful discussion: "…being respectful to the parent and the school, and you know, trying not thinking that we have necessarily got it right and got any answers" (CP3, L.688-691). Listening to the YP's perspective is seen to reduce professional assumptions: "So a lot of the work I do is about kinda going 'we all know what he *needs* to be doing', but actually it's about kind of understanding it from his perspective" (CP6, L.499-501).

CPs seek to gain a holistic understanding of the YP, triangulating information gathered from multiple sources, avoiding superficial formulations and acknowledging an individual's complexity: "…especially in adolescence(…) you have got so many different factors coming in and, you know, not to mention the young person's development and neurodevelopment and friendships and their contexts" (CP3, L.251-255). School observations, discussions with parents and school staff, and psychometric testing are all referred to as important in formulating the YP's needs. Psychological frameworks are considered helpful, but only provide a scaffolding: "Yes, you can have psychological models in working with anxieties and things(…) but you need to consider every bit of that person in order to work with them" (CP5, L.245-248).

Furthermore, CPs treat diagnoses with caution: "it is important that you then go on [beyond the diagnosis] to erm continue the conversation to think about the aspects of a person's limited experience that aren't encaptured by the diagnosis" (CP2, L.408-410). Diagnoses are seen as a useful vehicle for communicating, but further exploration is essential: "So why is someone acting out, why are they busy, why are they sort of yep, fidgety, cannot rest, cannot settle…" (CP5, L.49-51)". CPs perceive their role to be working with the YP and others around them to bring *meaning* to a problem presentation, rather than reducing it to a label.

Through deconstructing the difficulty and collaborative formulation, next steps can be agreed: "it's about helping people to learn to cope with their symptoms(…) and feel like they are taking some control(…) help them to get on with as much of their normal life as they can" (CP1, L.1186-1193). CPs consider themselves flexible and adaptable: "we might try family work with them, that might just not work and then we'll try kind of a variety of other things" (CP4, L.121-123). CPs perceive themselves as listening to the YP and their family; providing a service tailored to the specific need.

4.3.1.2 Specialist and in-depth

This is a well saturated theme: CPs perceiving themselves to specialise in different areas, offering in-depth support around specific, complex difficulties.

A CP service delivery model is described as having "pathways within our pathway" (CP4, L.95), allowing YPs to be referred to specific teams. Their clients' needs are regarded as complex, requiring a depth of knowledge: "'What's the distress about?', I mean, that might involve what the educational psychologist is doing as well, but it can be a, I guess, a more detailed focus on distress, where it's related to mental health" (CP3, L.1023-1027).

Using their specialist knowledge, CPs outline a variety of interventions they can offer, for example: psycho-education; strategies relevant to the specific need; and therapeutic sessions to progress the YP's capacity to understand and manage their MH.

> So using the kind of CBT model in terms of, 'well, let's challenge that thought, well actually, that's so unlikely to happen', and literally within two days of him kind of going 'well that-that's not really going to happen is it?' He said, 'Well actually, I can now sleep in my bed'. (CP6, L.585-589)

CPs considered direct work and the management of specific MH difficulties as part of their role, for example, "helping them manage their symptoms and learn other strategies for managing their stress and so therefore hopefully reducing the frequency of which it happens" (CP1, L.1133-1135). Evidently much of their work involves in-depth support for an individual YP.

4.3.1.3 Supporting systems

CPs perceive themselves to work with the systems around a YP through sharing information with schools and families about a specific difficulty, or a specific strategy: "running my sessions in the school setting, with a TA alongside me, doing, seeing and modelling" (CP6, L.624-626). There is little evidence of CPs considering systemic working, that is supporting change at a systems level, to be their role. The CP's role in effecting change within systems consistently relates to a specific YP:

> You [the CP] might have an opinion that the way the school's handling this particular situation or this particular child isn't very helpful(…) you might be sort of sharing your understanding, so that can influence how they then(…) deal with that child. (CP3, L.469-476)

Two participants mention that they facilitate multi-disciplinary meetings to disseminate effectively information about the YP, however sharing information is highlighted as an area of challenge: "there's been a couple of cases recently, where like a really great detailed report has come through from ed- from an Ed Psych and we did- we had no idea was ever involved" (CP4, L.765-767). CPs value sharing information and strategies when a specific need has been identified.

CPs consider their role in supporting the family system as important, acknowledging that their view can hold great authority: "parents often find it very helpful for us to get in contact with the schools to kind of have some of those conversations, because they just feel it gives it a little more validity" (CP4, L.480-483). There is a perception that the CP can bring meaning to a problem at different system levels: "They [the school] often look to us to kind of say(…), 'has this person got a sort of valid reason for not being in school(…)' So you sort of have this rather powerful role" (CP3, L.629-632).

4.3.1.4 Limitations

CPs acknowledge the limitations of their role, and three of the participants had chosen to leave the NHS in the pursuit of less restricted working conditions.

> …before you could even start thinking about whether you could actually offer a service to that, it was almost, 'do they meet that threshold?' and if they didn't, then even if there was a need, you had to kind of discharge and couldn't provide a service. (CP6, L.135-139)

CPs view high thresholds as frustrating and needing to be reconciled; and their service delivery model to be limited: “being in this role [foster caring] has really been humbling in showing me how little one hour a week of a therapy session is” (CP2, L.718-720). Seeing YP in a clinical setting for short sessions is acknowledged to be limiting: “Because when they come here and situation is very novel, and you know, so obviously you get a better snapshot of the child [in the school setting]” (CP4, L.584-586).

4.3.1.5 Variable capacity for school work

CPs have varying perceptions of navigating the school system or their capacity for direct work with schools; ranging in what they consider as appropriate, feasible, and necessary levels of engagement.

Some CPs consider themselves capable of navigating the school system through their own children attending schools and their psychological training: “one of the most valuable aspects [of training](…) was the opportunity to work in a range of services(…) it developed my confidence in the fact that the skills I had were transferable” (CP2, L.614-624). Through listening well, and prioritising accessible and jargon-free communication, some CPs feel equipped to work with schools: “I might be really interested in these quite abstract systemic ideas(…) [but] might not connect very much with the teacher(…) [so] I have to be quite pragmatic about translating some of my thinking” (CP2, L.651-656).

Some CPs “hope [they] are seen as being accessible and erm helpful [to schools]” (CP5, L.511), available to answer questions or offer consultation. One CP seeks to build rapport with schools: “sometimes it, yes, school meetings, observations(…) you end up having really good relationships. You get to know what the schools are like in dealing with certain erm client groups” (CP5, L.484-487). Some CPs perceive working with schools as possible and beneficial.

However, it also emerges that some CPs feel ill-equipped to work with schools, and considered it outside of their remit. Logistically, communicating with schools is considered difficult: “teachers teach most of the day, and that’s what they should be doing(…) so you do this sort of telephone thing, trying to get hold of each other” (CP3, L.517-520). Some CPs are unsure who to liaise with in schools, and feel the education

system changes too quickly to navigate: “when they want us to be more involved in terms of thinking about school placements for children and then I-I-I think I feel a little bit out of my depth” (CP4, L.533-535).

Some CPs do not consider direct work with schools to be their remit: “Theoretically, we’re not really meant to work directly with schools, ’cos it’s health…” (CP6, L.707-708). Most CPs’ referrals are through other health professionals, such as GPs, to limit their work load: “we don’t have the resources to have kind of an ongoing conversation with schools about kind of management and what’s happening” (CP4, L.500-502). Furthermore, work with schools is seen to potentially clash with the role of the EP: “I don’t want to go stepping on EPs’ toes(…) and also I don’t want schools to think that I’m a back door so they don’t have to pay for EP services” (CP1, L.1759-1762). The boundaries between the CPs’ role and EPs’ role in schools is unclear.

These views are summarised and compared with those of EPs’ in section 4.4.

4.3.2 How do CPs perceive the role of other professionals in supporting MH in secondary schools?

Five themes emerge in CPs’ view of other professionals supporting the MH of YPs in secondary schools. Three themes relate to the EP: EPs are considered *experts in school*; CPs benefit from this knowledge through *collaborative working*; however, EPs are seen to have *unclear professional boundaries* in the area of MH. EPs are considered to be neglecting their area of expertise in schools, hence the two themes are connected with a dotted arrow in the thematic map (Fig 4.3). A perception that schools can offer *preventative support* emerges as a fourth theme; and the final theme is the view that MH is *everyone’s* business, highlighting the role of social care, family and the YP.

4.3.2.1 EPs: Experts in schools

EPs are perceived to have specialist knowledge of learning needs and education provisions, and the capacity to work with school systems: “[EPs] kind of stepping in and maybe doing some assessments to see: where would this child be best placed?” (CP4, L.694-695). Two CPs consider cognitive assessments to be a valuable aspect of the EPs’ role:

> You need to understand what life is like for them and what are their intellectual abilities like, and what's their learning styles and stuff and we are not trained to do, you know dyslexia tests and erm, those other things (CP5, L.714-717).

EPs are understood to carry out cognitive profiling.

EPs using psychological skills in the school context is considered appropriate: "…having an individual understanding of a young person in terms of their sort of learning and their personality and their wellbeing(…) but then support the school probably to move that forward" (CP3, L.992-996). CPs acknowledge that many EPs have not been teachers, and they are practitioner psychologists, using psychology to formulate the YP's need and further schools' understanding.

4.3.2.2 Desire for joint working with EPs

There is a desire for joint working and collaboration with EPs: "I think it would be quite helpful for educational and clinical psychologists to work together, with the opportunities for learning from each other and from differences in perspective to enhance our work" (CP2, L.862-865). EPs' expert knowledge is considered useful for CPs: "I might have tried to use an educational psychology colleague, just to try to understand(…) is there something about the culture of the school" (CP3, L.924-927); their combined knowledge offers a more holistic understanding of the YP.

However, there is no consistent view of how this could be achieved. Some CPs consider a greater parity in their roles to be helpful:

> I am more interested in making sure that there is as much opportunity for anyone, for everyone to access good wellbeing care, which will mean, you know, greater cross-over; greater flexibility; greater numbers of people being in a position to deliver that. (CP6, L.1136-1141)

Through emphasising the commonality of their desired outcomes: to "make life a little bit more manageable for those people [YP]" (CP4, L.834-835), it is suggested that EPs and CPs could use their similarities to do-away-with the different titles, to "support the role of a *Practitioner* Psychologist" (CP6, L.1055), and meeting the large demands on services.

Other CPs acknowledge contrasts in the professions' theoretical frameworks and consider greater coherence to be important:

> It just adds to complication if you have got all these different psychologists with different ideas, different ways of working and there should be a way to get to the core of what we are doing, get to the core principles of our work, come to a common sort of sense to what the psychological approach is about and be able to communicate that. (CP2, L.899-905)

However, it emerges that some CPs feel clarity around the professions' *differences* is important: "I think the overlap would be helpful in terms of what you bring to the table(…) [but] it's about where those thresholds are" (CP5, L.792-795). Identifying difference could enable more effective collaboration: "If we both had clear remits to be involved, I would much prefer to do it jointly(…) then you know exactly what the others' saying and who's doing what" (CP1, L.1744-1748).

Communication is identified as a route to developing greater clarity: "Us and Educational Psychologists kind of talking a little bit more, could only lead to kind of better understanding; better formulation; better kind of joint working" (CP4, L.859-861). Communication is important in achieving either greater parity or better clarity around the distinct roles. The unknown is described as evoking anxiety: "it raises our worries about what we know and don't know, and you might sort of show me up as not a good psychologist because you kind of have done such and such training" (CP2, L.970-973). Greater clarity would reduce suspicion and misconceptions.

A final sub-theme is the perception that joint-working is hindered by a lack of resources: "You guys [EPs] are just, you're very inaccessible I suppose is the feeling" (CP4, L.795-796); and challenges at a systemic level: "Organisational structuring can make it more difficult(…) confidentiality clauses, the-the-the inflexibility of organisations being able to share information easily, and the pressures of daily grind, of the workload" (CP6, L.1151-1159). Solutions in overcoming these systemic challenges are not evident in the data.

4.3.2.3 EPs: Unclear professional boundaries

A less saturated, yet evident theme is concern at EPs' seemingly unclear professional boundaries. EPs are perceived to have moved away from psychometric assessment, a

skill which CPs considered very useful: “it’s quite confusing from my perspective(…) they used to be very much more focused on psychometrics, helping understand a child in terms of what their academic ability is and difficulties were” (CP5, L.642-645). This important aspect of their role is seen as neglected.

EPs are seen to be “doing more things, but less of it(…) providing a bit of information, but it doesn’t quite seem to be enough in terms of what’s going to help this individual” (CP5, L.659-663). The EP role is seen as becoming broader and shallower, lacking detail or rigor. “[EPs] will say ‘they have had VIG [Video Interactive Guidance], and they have done a PATH [Planning Alternative Tomorrow’s with Hope]’(…) and it’s sort of like they are seen as these discrete, you know, interventions that erm have, have had their impact and now are done” (CP2, L.933-937). It is suggested that EPs perhaps lose sight of the bigger picture through dipping into too many approaches.

CPs are also concerned that EPs are working beyond their training: “because you haven’t had that training…” (CP6, L.1082), and without supervision: “if they don’t sit within a mental health service, then it can be quite dangerous to do mental health interventions that they are not supervised on…” (CP5, L.846-849). A particular concern is EPs carrying out therapeutic interventions, and it is considered important for EPs to understand their limits.

Furthermore, for one CP this blurring of boundaries is perceived as a threat: “there has *got* to be a difference between Educational Psychology and Clinical Psychology(…) if you are not trained to do it, then I think(…) we need to stick to our professional training and not step outside of it” (CP5, L.866-870). EPs are also seen as straying into the role of PMHW: “they [EPs] seem to have gone into more of the emotional wellbeing field, which is what the primary mental health workers field(…) has clearly been, what they have always done…” (CP5, L.685-687). Greater clarity and variance is desirable for some CPs, perhaps excluding MH from the EP agenda entirely.

The CP seeks to make sense of these shifts: “in terms of [EPs] going into doing VIG, for example, and that was my understanding was a bit of bringing some finances in…” (CP5, L.648-650). Services are considered short of resources, and needing to build income through developing new tradable skills.

This view is not unanimous, as some CPs trust EPs' judgement: "I do sort of believe that(…) the educational psychologists would have done whatever they needed to do for the question that they were trying to answer" (CP3, L.880-882). Furthermore, it emerges that most CPs feel unsure of the EP role as they "don't see much of erm Educational Psychologists" (CP5, L.817-818).

4.3.2.4 Schools: Preventative support

Schools are perceived as potentially offering preventative support for the MH of YPs: building YPs' resilience, providing a secure relational base, and identifying early warning signs of difficulty. However it is acknowledged that schools will vary in their capacity to do this.

School staff are considered able to notice changes in YPs' behaviour: "not necessarily a concern that there is a *problem*, but just(…) raise a concern, umm a feeling, a hunch(…) a teacher could flag those concerns" (CP6, L.1018-1021). CPs anticipate that these early insights could be collated by a pastoral staff and communicated to the relevant health professionals if the difficulties escalate.

School staff could provide secure attachment: "can we establish that-that-that safe, therapeutic relationship with someone in his(…) immediate system(…) whether that's a TA [Teaching Assistant](…) his teacher, or a SENCo [Special Educational Needs Coordinator], we've got that resilience there" (CP6, L.617-621). This allows the YP to feel "listened to, understood, respected, valued" (CP3, L.572), enabling the YP to flourish. Staff can be an advocate for the YP if difficulties escalate, "rather than just blanketly applying the behaviour policy, they can tweak it to make sure(…) they're doing what's in the best interest of the child" (CP1, L.1624-1627). Relationally, schools are seen to provide an important support for YPs' MH.

The school curriculum could build YP's resilience: "I think it's about pulling all of those initiatives together(…) friendship formation; anti-bullying stuff(…) is about maintaining wellbeing" (CP6, L.968-971). Increased training could extend schools' potential further: "I think it would help teachers if they were offered, you know, additional training in specifically psychological models of understanding emotional

wellbeing" (CP2, L.781-783). Schools have a role in building YPs' understanding of MH.

However, schools are understood to have limits: "to some degree, they have an impossible job(…) there is so much inclusion in what teachers have got to do" (CP5, L.514-515). School staff are often extremely stretched, and lacking information:

> They [schools] won't necessarily have the background information to explain why the child's behaving like that, and therefore what the intervention needs to be to encourage them not to behave like that. They'll be applying the school's behaviour policy(…) whether it's a positive or negative one, across the board. (CP1, L.1616-1621)

A lack of information and insight may limit staff's capacity, and some schools are perceived to be unwilling: "other schools are very much 'Take this child off our hands and unless you can bring this child back to fit in within our system – great, or otherwise we don't want to know'" (CP6, L.876-878). Nonetheless, schools are seen to play a valuable role in promoting MH.

4.3.2.5 MH: Everyone's business

This final theme suggests that MH is "everybody's business" (CP1, L.428-429) through supporting YPs to reach their full potential. Different professionals are mentioned: Social care workers identify family stressors, and support the family's needs; PMHWs are perceived as providing support to schools, offering consultations, early intervention, and training. "[PMHWs are] training around mental health in schools so that there's a little bit more awareness" (CP4, L.644-645).

Families are understood to have an important role in providing a secure base for the YP, and developing their emotional literacy: "…just some basic really powerful things that parents can do that would really help with their child's overall(…) emotional development…" (CP5, L.279-282). And finally, the role of the YP: "they themselves can be an early barometer…" (CP6, L.1002-1003), learning to understand their own needs.

4.4 Summary of EPs' and CPs' perceived roles of professionals supporting the MH of YP

The following summary seeks to provide a response to RQs 2 and 3.

EPs perceive their role as fluidly meeting the needs of YPs where other services are limited, demonstrating flexibility in learning new skills, as far as training and supervision allow. Frustration is felt at how stretched their role is becoming. CPs also see EPs increasing the breadth of their skill set, at the expense of having in-depth knowledge about cognition and learning styles. CPs regretfully note the reduction in EPs' psychometric testing, and highlight risks in EPs practicing therapeutically without appropriate training or clinical supervision. The perceived motives for this shift differ, with EPs seeing themselves as filling gaps left by other services, whilst CPs hypothesise financial incentives.

EPs unanimously see working with schools as an aspect of their role, facilitating systemic changes in supporting the YP. CPs view EPs as a valuable resource both for schools and for sharing school related information with health services. CPs varied in their levels of involvement with schools, whereas EPs view CPs as lacking important involvement with schools, often resulting in narrow, problem focused pieces of work with the YP.

The depth of CP work is seen as both a strength and a danger by EPs, inevitably leading to high thresholds for accessing CPs, increasing the perceived range of work which EPs must take on to meet the needs of YPs. CPs consider their role to be appropriately in-depth, also acknowledging the possible limitations of extremely high thresholds and working in clinics for time limited sessions.

Where CPs lack the capacity to work in schools, both EPs and CPs perceived PMHWs to provide health support in this setting. However, EPs view PMHWs as an inferior alternative to CPs' input, whilst CPs perceive PMHWs as invaluable with a wide range of skills effective in schools. Furthermore, CPs consider EPs to be inappropriately adopting some of the support PMHWs are able to offer.

Schools are considered by both professions as potentially being able to promote MH through building relationships with students, noticing changes in their behaviour, and teaching and modelling resilience. EPs also consider a whole school ethos of promoting wellbeing to be important. However schools are understood to be stretched, limited in resources, and sometimes unwilling to engage in this area of support.

There is evidence of some similarity in the roles EPs and CPs perceive themselves to have. Both EPs and CPs view an important aspect of their own role to be understanding the YP as an individual, with unique experiences within the complex stage of adolescent development. Triangulating information, building therapeutic relationships and approaching MH diagnoses with caution is evident in both professions.

Joint working is seen by both professions as a means to provide a more cohesive service for YPs. However a number of factors are seen as preventing this from happening. CPs are uncertain of the EPs' role, and EPs perceive other professionals' confusion at their role as limiting the support they are able to offer. A level of suspicion and uncertainty is evident in both groups, partly evoked through a reliance on anecdotal understandings of the others' role. It is unclear whether the preferred way of working would be an increase in overlap between the two roles, or a greater clarity of the professional boundaries. The lack of resources in both services is considered both a limiting factor in further joint working, and a motivator in the need to initiate greater collaboration. A necessary first step in resolving these difficulties is seen to be better communication.

4.5 CONCLUDING THOUGHTS

EPs tend to maintain a social constructionist approach to MH, acknowledging the impact of language and perceiving MH difficulties to be a subjective experience for the individual, resulting in a range of different constructs of MH. CPs also acknowledge the variability of experiences, but consistently define MH difficulty to be enduring emotional distress, understanding MH within a developmental framework. Although both professions seek to avoid stigmatising language and reductionist approaches, CPs appear to approach diagnoses with a greater flexibility. These contrasting constructs of MH are explored in the following chapter.

Evidently, both professions view promoting the enduring wellbeing of the YP as the most important factor in offering support, however their approaches differ in many respects. Limitations are observed in each other's practice, and their own, due to contrasting theoretical positions, varying priorities, and a lack of resources. In various ways, they do not share an understanding of the EP or CP role. Strengths are also observed in both roles, but there remains an uncertainty around how to best complement each other's work.

Schools are consistently perceived to be an important resource in supporting the MH of YPs. However, they are understood to be stretched and in need of greater professional input. There are mixed views around who is best positioned to offer schools this support, and in what capacity.

The following chapter will discuss these findings in greater depth, connecting it to the wider literature.

CHAPTER 5: DISCUSSION

The following chapter incorporates the findings of the current study with the wider literature: exploring the way MH is constructed by professionals, considering tensions between the perceived roles of the EP and CPs, and examining ways in which schools can be supported. It is suggested that the EP and CP roles are largely complimentary, but a clearer understanding of one another's role must be achieved to enhance collaborative working. It is also argued that secondary schools would benefit from greater clarity of professional roles, and training on MH. Implications are drawn based on these commentaries. The researcher's reflections on the study, methodological limitations, and possible future research end the chapter.

5.1 DISCUSSION OF THE FINDINGS

5.1.1 WAYS IN WHICH EPS/CPS CONSTRUCT THEIR UNDERSTANDING OF MH

RQ1 in the current study examines EPs' and CPs' constructs of MH, and their perceived approaches to supporting YPs' MH in the context of secondary schools. The way in which these perspectives have been developed is explored, noting the absence of a diagnostic framework, and the significance of epistemological positioning.

5.1.1.1 Constructing an understanding of MH

Although EPs and CPs work with similar clients with a shared aim of achieving positive MH, the current study suggests that they hold different constructs of MH. EPs experience uncertainty in defining MH, regarding MH as a subjective experience, whilst CPs confidently describe MH difficulties as an expression of enduring distress. To gain insight into these differences, literature regarding professionals developing an understanding of complex concepts is examined.

Strasser and Gruber (2015) suggest that a significant part of the learning process for professionals is the integration of experience and declarative knowledge. They find that more novice mental health counsellors have less integrated knowledge structures, whilst more expert counsellors organise their knowledge into scripts of integrated knowledge and experience. Similarly, Charlin, Boshuizen, Custers, and Feltovich (2007) find that

medical professionals form “illness scripts” which integrate experience and knowledge, enabling them to shift from being a novice to an expert. Incorporating knowledge with experience is evidently important in developing professional expertise in a particular area.

This process provides insight into psychologists’ professional development. Both EPs and CPs are required to understand psychological theories of development, and “develop psychological formulations using the outcomes of assessment, drawing on theory, research and explanatory models” (HCPC, 2015, p.22). However, the HCPC states that CPs must “understand therapeutic techniques and processes as applied when working with a range of individuals in distress including: …difficulties related to anxiety; eating; psychosis…” (HCPC, 2015, p.23); whereas the role of the EP places a greater emphasis on being “able to develop and apply effective interventions to promote psychological wellbeing, social, emotional and behavioural development” (HCPC, 2015, p.24). These nuances are evident in the current study: EPs refer to the importance of working systemically, promoting emotional wellbeing; whereas CPs discuss the scope of working directly with YP regarding their specific MH needs.

These variations influence the way EPs and CPs construct MH: EPs refer to EWB, acknowledging minimal training or experience around MH difficulties. EPs appear to lack declarative, factual knowledge of MH difficulties, yet manage to construct a concept of MH, and how it can be supported in secondary schools. It is likely that EPs reduce the unknown to what is known, constructing their understanding of MH within familiar psychological frameworks. Dutton (1995) suggests that there are three strategies used by experienced professionals in guiding their practice: pattern recognition, knowing-in-action, and naming and framing. These stages imply a process of filling in gaps by referring to familiar patterns, instinct, and theoretical frameworks. EPs appear to have limited experience around MH, and therefore rely heavily on framing the concept within familiar theoretical models. For example, EPs frame MH difficulties as partly socially constructed, and seek to understand MH as a subjective experience influenced by many different internal and external factors, reflecting aspects of their theoretical training.

Furthermore, EPs primarily refer to positive mental health, reflecting their tendency to adopt a positive psychology approach (Joseph, 2008). Their perspectives are supported

and possibly influenced by policy documents such as *Future in Mind* (DoH, 2015), which purports to promote, protect and improve the MH of children and YPs.

CPs, however, demonstrate confidence in working with MH difficulty, conveying specialist knowledge through their professional experience and training in this area. The CPs appear to develop their constructs of MH through combining their knowledge of attachment theory and developmental frameworks with practice, organising their understanding into scripts (Charlin et al., 2007; Strasser & Gruber, 2015).

5.1.1.2 An implicit absence within the constructing of MH

One of the tensions in the current study is the desire to adopt aspects of a social constructionist approach to MH, and a reticence towards using diagnostic labels. There is an implicit absence of reference to the medical categorisations of different MH difficulties.

Practitioner psychologists tend to practice within a systemic, developmental framework, acknowledging that YPs are influenced by a wide range of factors with rapidly changing presentations (WHO, 2005). Georgaca (2013) suggests that from a social constructionist perspective:

> Diagnosis is not an act of discovery of a pre-existing entity lying inside the sufferer and manifesting itself in symptoms, but a process of actively formulating a case, transforming the client's experiences to symptoms of a disorder and attributing a disorder to a person as an explanation of the experiences reported. (p.57)

Applying a diagnostic label to a YP may undermine the complexity of the experience. Hak (1989) found, for example, that psychiatric diagnosis of psychosis involved medical professionals systematically ignoring information in interviews which did not fit the diagnostic criteria.

Furthermore, EPs express concern at the possible stigma attached to diagnoses, a risk well documented in previous literature (Ben-Zeev, Young, & Corrigan, 2010; Corrigan, 2007). Kranke, Jackson, Taylor, Landguth, & Floersch (2013), for example, identify that self-stigma in adolescents living with MH difficulties develops through the individual applying negative mental illness labels from society to him/herself, endorsing

the negative public stereotypes, internalising the rejection, feeling shameful, then disengaging. Similarly, Gulliver, Griffiths, and Christensen (2010) found that young people were put off asking for help, partly due to public stigma, but also due to *perceived* public stigma, and self-stigmatising attitudes to MH.

Mehta, Kassam, Leese, Butler, and Thornicroft (2009) found that public attitudes towards people with MH difficulties in England worsened between 1994 and 2003. It is hypothesised that this is in part because "campaigns to address discrimination against mental health service users have so far tended to be based on a biomedical model" (Sholl, Korkie, & Harper, 2010, p.26). Read, Haslam, Sayce and Davies (2006) found that psychosocial explanations for schizophrenia led to more positive attitudes towards the difficulty. Similarly, Lindley (2009) found that teenagers were less discriminatory towards YPs with MH difficulties if they were encouraged to perceive the problem as a consequence of circumstances.

To a great extent, managing stigma appears to be related to developing an understanding and empathy with the individual experiencing the difficulty (Pinfold et al., 2003; Schulze, Richter-Werling, Matschinger, & Angermeyer, 2003). Psychologists have a valuable role to play in this discussion, reminding health colleagues of bio-psycho-social approaches to formulation, modelling the shift away from more biomedical models.

Whilst it could be suggested that classifying MH difficulties is unnecessary and unhelpful (Johnstone, 2014), it is possible that acknowledging aspects of diagnostic categorisation may enhance professional understanding of MH. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) classifies MH difficulty into groups with different evidence based treatment paths, including neurodevelopmental disorders such as autism spectrum disorder, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, and various others. However, in the current study, the above presentations are not distinguished from one another.

CPs in the current study refer primarily to mood disorders and anxiety disorders, discussing an interplay between internal and external factors in both the onset and the management. Reference is made to MH difficulties, such as psychosis, as being

'enduring emotional distress'. However in current literature, psychotic disorders, for example, have a less evident cause and there is ongoing investigation into the significance of environmental factors (Cougnard et al., 2007). It is unclear how far a social constructionist framework can be extended where evidence suggests that biological factors are involved – a currently live debate (Bentall, 2016). Further consideration of the tensions between medical models and psychological frameworks is important to develop a clearer understanding of supporting MH and providing best care for the YP.

5.1.1.3 Evidence based practice?

Of note, none of the participants in the current study refer to evidence based practice in their constructs of MH, perhaps due to their limited capacity to analyse research in their day-to-day practice (Fox, 2003; Gilbody & House, 1999), or through viewing randomized control studies as "a number crunching dehumanising style of research practice" (Fox, 2003, p.96). It has been suggested that practitioner psychologists "know what to do through reflecting on [their] practice, not from an evidence-based research" (Fox, 2003, p.96). In the current study, for example, one EP claims that they would be unlikely to change their values according to research, unless their experiences fitted it. However, it may be that developing a greater awareness of evidence based practice would enhance professional understanding of MH.

5.1.1.4 Summary

Evidently there are important considerations when working with diagnostic categories. Practitioner psychologists acknowledge some of the advantages of diagnostic summaries of MH presentations, but remain reticent in using them in practice. Possible implications of this will be considered in the following section.

5.1.2 TENSIONS IN THE PERCEIVED ROLES OF EPS AND CPS SUPPORTING MH IN SECONDARY SCHOOLS

RQs 2 and 3 in the current study examine the self-perceived roles of the EP and CP, and their perceived role of the other. Although each profession broadly claims to see the other in a positive light, there is a pervading sense of suspicion and frustration at the

perceived short-comings in the other's role. It is argued below that this is partly provoked by misplaced expectations, a professional tendency to focus on less successful experiences, professional defensiveness and systemic pressures.

5.1.2.1 A suspicion of the other / Misplaced expectations

Throughout the data, EPs and CPs have contrasting and sometimes conflicting views of the other's role. For example, CPs see EPs as expanding the breadth of their practice, whilst reducing an emphasis on psychometric tests and cognitive assessments. EPs express some concerns around the need to know 'a little about a lot', and the limited potential for clinical supervision; however, they view this shift as filling gaps where other professionals have no capacity. EPs broadly feel equipped with the necessary psychological skills and are willing to seek further training in areas which are less familiar. In contrast, CPs express concern around the safety of EPs' practice, uncertainty with their training backgrounds, and reticence at their practice without clinical supervision. EPs are seen as *overlapping* with other professionals, particularly PMHWs, and CPs query if EPs are financially incentivised to take on unnecessary interventions.

Furthermore, EPs consciously avoid psychometric testing as it is seen to be an unhelpful, reductionist approach, providing little insight into the YP's needs. This position holds historical significance after Gillham (1978) acknowledged that EPs had based their practice on a deficit focus of measuring and quantifying children and YPs' levels of need, prompting the 're-constructionist' movement. A vision was established of EPs being "an agent for change in schools informed by an understanding of ecological approaches and systems theory" (Boyle et al., 2008, p.36). However, CPs maintain the view that psychometric assessments are useful in adding to the bigger picture of the YP's needs, and express frustration that EPs no longer prioritise cognitive assessment.

Similarly, EPs hold expectations of the CPs' role which are in conflict with the CPs' perspective. CPs perceive their role as allowing in-depth work with YPs, reducing the capacity for more general involvement with systems around the YP, such as schools. EPs hold a similar understanding of the CP's role, but question whether the intense nature of the CP's work limits their involvement to an extremely narrow group of YPs

with very specific needs, and misses the opportunity of more YPs benefiting from CP support through CPs working more closely with schools.

5.1.2.2 Negative bias and stereotyping?

It is possible that this mutual confusion is partly due to anecdotal understandings of the other's role. Many of the experiences of the other recounted in the current study, are based on negative interactions. Individuals are more likely to remember experiences which have been negative (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001), and are more likely to recall the details *inaccurately* than a neutral experience (Rimmele, Davachi, Petrov, Dougal, & Phelps, 2011). It could therefore be argued that such anecdotes might be inaccurate.

Feinberg, Willer, Stellar, and Keltner (2012) found that sharing negative evaluative information within a group about a target had positive impacts on the group – reducing the negative effect created by observing the negative event, and increasing cooperation within the group. This may be considered in-group, out-group psychology, enhancing group membership, whilst implying that professionals are more likely to share *negative* observations of practice in other teams. This could result in an increased suspicion of the 'other', and reduced potential for effective joint working.

The current study suggests some discrepancy between one set of professionals' self-perceived qualities, and those noted by the other. EPs share anecdotal, second-hand, experiences of working with CPs who show a lack of flexibility when working with families or schools, dangerously high thresholds for access to their service, and the discharging of YPs who were unable to engage with the service they were offering. CPs however, describe their flexible working approach, seeking to meet accessibly the needs of families and YP, and adapting their practice to suit the specific needs.

Research suggests that negative perceptions will prevail when forming opinions with a lack of information. For example, Richey, Koenigs, Richey, and Fortin (1975) found that when information was given about an unknown person, one negative neutralised five positive descriptors when the subjects were asked to rate the unknown individual's character a week later.

Furthermore, research shows that familiarity does not necessarily increase positive perceptions. This can be explained through an exploration of dual process models of forming judgements of others: in some situations, people are motivated carefully to form an opinion of another, whereas often people engage in the more rapid judgement of an object or individual through simple cues or heuristics (Smith & DeCoster, 2000). When an individual or group is familiar, people tend to engage in lower levels of systematic processing (Garcia-Marques & Mackie, 2000), reducing the amount of effort required to make sense of the individual. Smith et al., (2006) found that familiar individuals, who were not known personally, tended to be the subject of stereotyping. When one "frequently sees another person without engaging in meaningful interaction or forming an actual friendship" (Smith et al., 2006, p.472) then there is a lack of motivation or capacity to form an opinion analytically, thus stereotyping may occur – this effect is not "counteracted by individual knowledge or emotional involvement" (Smith et al., 2006, p.472). This possibly reflects the perceptions expressed by EPs and CPs.

The current study suggests that EPs and CPs experience limited joint-working or personal relationships with the other. Rather, they are consistently aware of their presence, potentially with a sparse range of negative or neutral memories and anecdotes from colleagues. It is therefore likely that stereotypical perceptions of the other form over time, potentially based on inaccurate information.

5.1.2.3 Professional defensiveness

In the current study, both professions experience pressures preventing work in their preferred ways, causing some frustration. EPs feel unable to support change effectively within the school systems as they are no longer resourced to carry out planning meetings or develop an overview of the schools' needs. Similarly, CPs prefer not to see YPs in the context of a clinic, but appear restricted by the historical pattern of clinic based work. Huebner and Mills (1994) examine the rate of 'burnout' in school psychologists, discovering that difficulties often develop when the psychologist, who has entered the profession with a desire to 'help people', is met with a frustrating emphasis on assessment. The suspicion of the other, and defensiveness around their own roles, may partly be due to EPs and CPs experiencing frustration at feeling unable to fulfil the roles they anticipated they would be doing.

Furthermore, CPs are increasingly losing autonomy around their therapeutic practice as funding for MH services are cut. For example, recent austerity measures have led to recommendations for welfare recipients to undergo mandatory cognitive behaviour therapy, a policy which met with much animosity from psychologists and psychotherapists (Ferraro, 2016; Guardian Letters, 2015). It was argued that 'get to work therapy' is not therapy at all and that CBT has only become widespread because it is cheap, standardised and easy to measure (Dalal, 2015; Ferraro, 2016; Miller, 2012). CPs are increasingly encouraged to use approaches which are convenient and produce quantifiable results, rather than using their professional judgement.

EPs and CPs may be seeking to establish the uniqueness of their own roles in protecting their own autonomy. Historically, this has been a tension for the EP. Frederickson (2002) quotes the Department for Education and Employment (DfEE, 2000)'s definitions of EP practices, noting that there is an emphasis on 'how' and 'where' EPs will practice, without describing 'what', allowing an ambiguity around the nature of EP work. More recently, *Future in Mind* (DoH, 2015) suggests that the DfE will be "developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools" (p.22), but there is very little mention of the EP's role in this current initiative.

There is a contemporary emphasis on services working together more closely, for example though the Children and Families Act 2014, which may raise further professional defensiveness. Jones (2006) examines the collaborative and conflicting aspects of multidisciplinary working within a care pathway for patients diagnosed with schizophrenia. Whilst the clinicians argued for clear role boundaries, they also defended their perceived control over aspects of health care. Conflict arose through professions being unwilling to accept plurality over roles or compromise professional autonomy, delivering care according to their "own professional silo with a clear sense of protecting professional boundaries" (Jones, 2006, p.25). The study found that these behaviours potentially hindered the needs of the patient being met. A similar tension may be true for EPs and CPs.

The services in the current study have recently gone through major changes in commissioning, shifting job descriptions. It is possible that the participants are looking to protect their jobs, determining the distinctiveness of their own roles possibly at the

expense of effective joint working – as in Jones (2006): "...jealously guarding against losing any of this ground; leading professionals to reassert professional boundaries by not standardising care and disengaging from the project [of multidisciplinary working]" (Jones, 2006, p.26).

EPs and CPs are highly skilled professionals who are increasingly being told what to do, reducing their sense of professional freedom. A number of factors may be influencing the sense of frustration and mistrust experienced between the two professions. Nonetheless, the current study identifies that EPs and CPs have a desire to work collaboratively. Implications for their practice will be examined later in this chapter.

5.1.2.4 Summary

It appears that EPs and CPs experience frustration toward each other, with a sense that the other is working both outside their remit and not doing the work which they *should* be doing. It is argued that this is due to a lack of clarity around the role of the other, based on anecdotal evidence and leading to negative assumptions, and professional defensiveness due to uncertainty around one's own role and systemic pressures.

5.1.3 SECONDARY SCHOOL'S ROLE

The study found that both participant groups consider schools valuable in building resilience, protective relationships and knowing the YP well enough to flag up difficulties if and when they occur. These views are in keeping with recommendations in *Future in Mind* (DoH, 2015) and the *Mental health and behaviour in schools: Departmental advice for school staff* (DfE, 2014) guidance.

Moreover, both EPs and CPs conceptualise schools as promoting MH, rather than tackling MH difficulties. Madge et al., (2008) found that school staff considered themselves to have strengths in both communicating with YPs, and understanding normal child development. Therefore, to some extent teachers may already feel equipped to offer the level of support EPs and CPs perceive to be their role.

However, the recent publication from the DfE (2014) suggests that schools should be completing SDQs to identify whether or not the YP is experiencing difficulties. In this

respect, both EPs and CPs in the current study hold different perspectives to current policy: they do not feel that schools should be conducting assessments. It is unclear why this perspective is held, but it could be hypothesised that EPs and CPs see school staff as already too time-stretched, or perhaps that including basic MH assessments in schools' remit will further reduce the clarity of the psychologists' role.

Further challenges to EP and CPs' perspectives of the schools' role are suggestions from previous literature that YP do not feel able to talk to staff about their MH difficulties (Kay et al., 2006), and that staff perceived themselves to have insufficient training to carry out specific direct work with the YP (Timson et al., 2012). Gulliver et al., (2010) found that YPs' concerns about the confidentiality of services put them off asking for help; this would likely be a concern in the context of seeking support in the school context.

Additionally, literature suggests that when MH is conceptualized in more deficit terms, school staff feel less equipped to offer support (Madge et al., 2008; Timson et al., 2012). Staff often feel stretched and under resourced, resulting in their seeking external practitioners to offer specific support to specific YPs who are presenting with difficult behaviours, rather than accepting more systemic support (Rothì et al., 2008). Potentially schools will require further input from appropriately trained professionals.

Furthermore, in the current study, EPs and CPs consider sign posting and referral as important aspects of the teachers' role. However, previous literature evidences that teaching staff feel ill-equipped to do this, due to uncertainty around referral pathways (Madge et al., 2008). Evidently there are a number of perspectives shared by EPs and CPs concerning schools' potential involvement in supporting MH which schools do not feel able to implement. The implications of this will be examined later in this chapter.

From the current research, however, different, distinct roles emerge in supporting schools: CPs work with schools regarding a specific child; EPs offer support in a more systemic manner, supporting staff to establish whole school approaches to promote MH, both of the staff and the students; and PMHWs are understood to offer expert advice around MH difficulties more generally. There is scope for the different professions to work in a complementary and cohesive way to support schools in managing YPs' MH.

School are considered to have an important role in flagging up possible difficulties, and offering a whole school approach to promoting MH. However, school staff are likely to require further training in this area, and previous literature suggests that it will be necessary to investigate YPs' willingness to engage with school staff in the manner suggested by EPs and CPs.

5.1.4 SUMMARY OF DISCUSSION ON FINDINGS

There are complexities in the way MH is constructed, dependant largely on professional knowledge and experience. Both EPs and CPs apply a developmental framework to their understanding of MH. EPs lack experience or training on MH difficulties, tending to adopt a more systemic approach to promoting MH; whereas CPs apply their experience and knowledge to create scripts around supporting specific MH needs. Both EPs and CPs espouse a social constructionist approach to MH, expressing misgivings towards a more medical model and diagnostic labels, and to some extent, bypass evidence based practice.

The current study shows that EPs and CPs experience some frustration toward each other and a lack of unity in the understandings of their different roles. It is hypothesised that this is due to a lack of detailed and current knowledge of the other's role, in combination with an increasing emphasis on collaboration between services. This appears to lead to negative assumptions about the other, and a sense of professional defensiveness, reducing the potential for effective joint-working.

EPs and CPs share the view that schools offer a valuable role through building rapport with the YP, noticing potentially problematic behaviours, and flagging these up to other services. Furthermore, staff are expected to provide possible secure bases for the YP, and whole school approaches to developing emotional wellbeing are considered effective.

Implications of these findings are now discussed.

5.2 IMPLICATIONS

Implications from the current study are outlined, suggesting ways in which EPs and CPs can most effectively support the MH of YPs in secondary schools. Findings imply that collaborative working is affected by contrasting professional constructs of MH, professional defensiveness, and ambiguity around job roles. The nature of these tensions will be explored, providing insights into potential ways forward.

5.2.1 SHARING CONSTRUCTS TO ENHANCE FORMULATION

It is evident through the current study that EPs and CPs hold a variety of different 'realities' regarding MH. Whilst the social constructionist would argue that each of these perspectives is equally valid, the critical realist might suggest that failing to reconcile some of these differences could confuse and undermine the care provided for YP. It is suggested that the strengths of each perspective could be incorporated through psychological formulation, and developing a clearer understanding of the other professionals' views of MH could improve collaborative working. The tendency to dismiss positions different to one's own, and a lack of knowledge about MH leading to a primarily theoretical understanding, will be addressed.

5.2.1.1 Various professional constructs of MH

CPs view MH difficulties as enduring levels of emotional distress; whilst EPs adopt a more social constructionist approach, with no shared understanding of MH difficulties and a focus on promoting MH. Both professions are wary of the more positivist model of medical diagnoses which continues to be dominant in MH services.

Strengths of each position can be acknowledged. Traditionally, the social constructionist examines the constructs of language: as outlined by EPs in the current study, this approach has the strength of proactively tackling stigma (DoH, 2015; Time to Change, 2016). The social constructionist approach also takes into account multi-cultural experiences (D'Andrea, 2000), avoiding Western-centric assumptions of diagnostic frameworks (Bursztyn, Afonso, & Black, 2013). This is evident in the perspectives of both participant groups in the current study.

CPs and, to some extent EPs, construct their perspectives within a developmental framework. The WHO (2005) highlights a strength of this approach, suggesting that professionals must be aware that as adolescents undergo rapid changes, all clinical diagnoses and identified needs are likely to be constantly changing.

Diagnoses, whilst presenting a number of challenges, can arguably be seen as supportive for the YP receiving them, increasing understanding of need (Rethink Mental Illness, n.d.), and communicating a large amount of information in effective shorthand. CPs in the current study acknowledge this position, noting that more services can be accessed as a result of a label. They resolve their concerns regarding reductionist attitudes through emphasising the importance of professionals expanding their view of the YP beyond the diagnostic summary. Elsewhere it is argued that psychological formulation could be an effective tool for reducing the need for diagnosis altogether (Johnstone, 2014).

5.2.1.2 An opportunity for enhancing formulation

The variety in views and terminology may be perceived as problematic and confusing. For example, in Rothì et al., (2008)'s study, it was unclear whether MH difficulties or promoting MH are being researched; and in her Annual Report, the Chief Medical Officer argues that there is a proliferation of terminology around MH which can lead to "confusion and lack of understanding" (Davies, 2014, p.2).

However, other literature suggests that an overreliance on any one approach can be problematic. For example, Ivey, Locke, and Rigazio-DiGilio (1996) suggest that counsellors exclusively focusing on the ideas that clients construct about their life experiences may lead to a failure to address the environmental factors which actually are contributing to their sense of well-being or distress.

Ward, Hoare, and Gott (2015) explore the shift from a positivist approach to nursing, to a more social constructionist epistemology, questioning the 'gold standard' status of evidence based practice, acknowledging that "the patient's physical body is not nursed in isolation from their mental self, their beliefs, their experiences or their social worlds" (Ward et al., 2015, p.451). The researchers resolve their struggle by acknowledging the

usefulness of discoveries made through positivist research, and apply these insights within their ever developing practice-based evidence (Ward et al., 2015).

It is understood that MH difficulties require a bio-psycho-social approach (Remschmidt & Belfer, 2005), and sometimes medication will be necessary in combination with psychosocial interventions (for example, *What works for whom?*; Fonagy, Target, Cottrell, Phillips, & Kurtz, 2005).

Psychological formulation arguably provides a means of resolving these contrasting approaches, placing the YP's voice at the centre of their care, incorporating more medical approaches and labels where the service user feels they are useful. Reflective practice allows the service user's story to be constructed rather than discovered (Harper & Spellman, 2006), combining "the psychologist's clinical and research knowledge (…) and the service user's expertise in their own life" (Johnstone, 2014, p.78). In supporting YPs' MH, formulation is found to encourage person centred, collaborative work, normalising problems and reducing service users' self-blame (Division of Clinical Psychology, DCP, 2011, p.8).

Team formulation is growing in popularity within multi-disciplinary teams with the advantages of: "gathering information in one place; minimising disagreement and blame within the team; increasing team understanding, empathy and reflectiveness" (DCP, 2011, p.9). In some situations, formulation appears to promote a cultural shift within a team (Johnstone & Dallos, 2013), in others, it is less explicitly recognised but can still be used as an extremely valuable addition to the treatment narrative, broadening the understanding of the YP's experiences (Christofides, Johnstone & Musa, 2011). Psychologists evidently have an important role to play in uniting some of the seemingly contrasting approaches to MH services, constructing a way forward which is "person-specific not problem-specific" (DCP, 2011, p.12).

5.2.1.3 Challenges to overcome

In practice, there are challenges to overcome in incorporating different professional perspectives. Various studies have investigated the tensions between positivist and constructionist epistemologies in health care. Corbin, a grounded theorist, reflects on her nurses training: "I found the quantitative part of the course pretty dry(…) there was

something about qualitative research that I found very appealing" (Corbin, 2009, p.36). Coyle and Williams (2000) describe the experience of combining qualitative and quantitative methods in eliciting the user views of health care, highlighting the importance of reflexivity.

Psychologists in the current study remain wary of health input. Ongoing debates highlight the possibility that psychiatric diagnosis could one day be considered redundant (Johnstone, 2014). However, in current context, psychologists have a potentially powerful role in uniting the different perspectives in multi-disciplinary teams. It is possible that EPs and CPs need to acknowledge the opportunities presented by different approaches to MH to allow maximum flexibility in collaborative formulation: in some situations, diagnoses are found to be supportive for the service user (DCP, 2011). Furthermore, a clearer knowledge of more medical models will allow the psychologists' more systemic, integrative approaches to be more convincingly promoted to colleagues in different services.

Formulation is a familiar concept for health professionals, for example, psychiatrists are required to "demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses" (Royal College of Psychiatry, 2010, p.20) during their training. Formulation could therefore be seen as a viable tool for enhancing multi-disciplinary working. It is acknowledged that drawing on the ideas of whole team can quickly enhance a formulation (Johnstone & Dallos, 2013), but the tricky part is helping everyone present to make sense of their contrasting feelings and intuitions about a problem situation (DCP, 2011): a role which the psychologist is well equipped to manage.

A further challenge highlighted in the current study is EPs' reluctance to work with the concept of MH difficulties or emotional distress, and their confusion around the relationship between MH, EWB, resilience and behaviours (Public Health Suffolk, 2015). EPs increasingly work with MH difficulties, following the inclusion of MH in the SEND Code of Practice (DfE & DoH, 2014), therefore it is important for EPs to have a clearer and potentially more unified understanding of this area, aiding multi-disciplinary working.

This may be achieved through more explicit training in the area, exposure to clinical work experience, as professionals tend to construct complex concepts through incorporating declarative knowledge and experience (Strasser & Gruber, 2015). Opportunities to reflect on constructs of MH are also likely to enhance EPs' realisation that more information may aid their understanding, rather than exhibiting over confidence in their current knowledge (Bensley, Rainey, Lilienfeld & Kuehne, 2015). In the current study it was found that the participants were challenging their own beliefs through the interviews, querying the source of their constructs, with seemingly positive effect.

5.2.1.4 Summary

Although EPs and CPs hold a variety of constructs of MH, it is argued that their different perspectives can be usefully combined through formulation. EPs appear uncomfortable with the concept of MH difficulty, thus it may be helpful for EPs to receive more training in this area and reflect on their own constructs to increase their flexibility when working with the perspectives of others professionals. This is particularly relevant as EPs are increasingly expected to work with YPs' MH needs.

Psychological formulation is a valuable tool in shifting MH services away from an emphasis on diagnostic treatment models, encouraging a more collaborative, person-centred approach to care.

5.2.2 COLLABORATIVE WORKING FEASIBLE AND BENEFICIAL

The current study highlights a shared desire by EPs and CPs to work more collaboratively. Their skill sets and perceived roles are complementary, offering the potential for holistic support of MH in secondary schools. A case for collaborative working is made, particularly considering the merits of "transdisciplinary collaboration".

5.2.2.1 Complementary skill sets

In many ways, EPs and CPs have the same agenda: seeking to understand the YP holistically and provide the YP with long term protective factors against pervading MH

difficulties. The findings show that they approach this in contrasting but complementary ways: EPs tend to work primarily with the systems around the child, whereas CPs offer a more in-depth focus on the child's needs; EPs place greater emphasis on preventative work, and CPs provide more reactive support when difficulties arise; EPs have expertise in the school system, and CPs work closely with families. The complementary nature of their skill sets present opportunity for effective, holistic, collaborative care.

CPs could use their expertise in MH formulation when collaborating with EPs, providing insight into the meaning and function of different MH presentations for the individual YP. EPs could thus be supported to see that acknowledging a presentation of emotional distress does not necessarily lead to stigmatisation for the YP, rather that formulation can bring meaning.

EPs could support CPs to maintain a more systemic perspective, using psychological formulation to adjust practice within the school environment: equipping school staff to devise supportive strategies around MH, and where necessary, to develop a less judgemental or fearful attitude toward the YP's presentation.

5.2.2.2 The benefits of collaboration

The Children and Families Act 2014 suggests that multidisciplinary working is to be aspired to. A lack of cohesion may lead to work being repeated, wasted resources, and confusion for families as multiple, seemingly similar professionals are involved (DfEE, 2000; NCTL, 2015). A lack of cohesion between services may lead to useful information being overlooked, reducing the richness of formulation when working with a YP.

Three different models of collaborative working are considered, suggesting that transdisciplinary collaboration between EPs and CPs may provide the best possible service for YPs as limited time and resources continues to be a restrictive factor in joint working.

Ritzema, Sladeczek, Ghosh, Karagiannakis, and Manay-Quian, (2014) present three models of collaboration: multidisciplinary, interdisciplinary, and transdisciplinary. Pohl and Hirsch Hadorn (2008) suggest that multidisciplinary working "approaches an issue

from the perceptions of a range of disciplines(…); but each discipline works in a self-contained manner with little cross-fertilisation among disciplines, or synergy in the outcomes" (p.429). This is evident in the current professional support of YPs' mental health, for example through Education Health and Care Plans (EHCPs). However, often support is disjointed and poorly coordinated (Hoeman, 2008).

Interdisciplinary working involves greater collaboration between professionals at each stage of the problem-solving process, allowing for greater understanding and co-agreed strategies and goals (DfEE, 2000; Garner, 1995). Finally, Ritzema et al., (2014) describe transdisciplinary teams as involving:

> a blurring of the traditional boundaries between disciplines and require that team members be open to doing activities that fall outside their typical scope of practice, while continuing to abide by the professional practice guidelines of the discipline, and also require a willingness to share knowledge, skills and responsibilities. (Ritzema et al., 2014, p.321)

Although there are ongoing discussions around increasing overlap in the EP and CP training, currently there are two distinct roles to be fulfilled. However, where possible, transdisciplinary collaboration could be considered. Bell, Corfield, Davies, and Richardson (2010) suggest that transdisciplinary collaboration allows for earlier, more effective intervention, and Hoeman (2008) finds that it reduces the duplication of services in the context of health services. These findings are likely to be applicable to professionals supporting the MH of YPs in secondary schools.

Furthermore, in the context of multi-service teams supporting children with developmental disabilities, Patel, Pratt, and Patel (2008) find that enhanced collaboration is most effective if there is an agreed mutual goal, a voluntary desire to collaborate, an equal sharing of resources and decision making, and a shared accountability for the outcome.

Another possible area of consideration suggests that avoiding one professional being the overt leader leads to better collaboration (Holloway & David, 2005; Ritzema et al., 2014). Further investigation will be required in the context of EPs' and CPs' collaborative working, particularly in seeking to overcome professionals' avoidance of plurality over roles and compromised professional autonomy (Jones, 2006). The

practitioners would need to be extremely secure in their perceived roles if they are not to feel threatened.

Practical steps towards collaborative working might involve open access diaries, improving the possibility of agreeing mutually convenient times for discussion (Ritzema et al., 2014). Knowles (2009) found that the reporting of case work is sufficiently different between psychologists and primary care providers that it limits the effectiveness of their collaboration. Steps have already been taken in unifying the format of recommendations through EHCPs, but potentially this could be considered further.

5.2.2.3 Summary

The current study suggests that EPs and CPs have complementary roles, and a desire to work collaboratively. Whilst it is likely that limited resources will continue to reduce the potential for joint case working, clear routes of communication could allow for advice seeking irrespective of formal involvement in a specific case. Time which is invested now in building frameworks for collaborative working, potentially following the transdisciplinary model, is likely to improve efficiency in the future.

5.2.3 A MORE COHERENT WORKING RELATIONSHIP

Whilst a desire for joint working is evident, a major limiting factor is the poor understanding of the other's role, leading to negative assumptions. EPs and CPs could develop a more coherent working relationship through building a greater level of trust and a clarity of roles, achieved through clearer communication and increased reflection on one's own biases.

5.2.3.1 Clearer communication and reflective practice

Frustration and suspicion of the other appears to be provoked by anecdotal, limited insights into the other's role. Vostanis et al., (2012) find that CAMHS workers have a greater empathy for educational professionals after developing a clearer understanding of their job role. Similarly, Farrell et al., (2006)'s review of EPs' function, identifies that schools feel other providers could carry out the work of EPs, so he suggests, "EPs

need to liaise with the local commissioners of their services to ensure that there is clarity of purpose in their activities so that the local commissioners and users of EP services can be confident about the EPs' distinctive contribution" (p.3). It is important that professionals make their roles known, seeking opportunity to communicate this directly to colleagues in other services.

Direct contact, and improved relationships between services, help to clarify roles and reduce professional defensiveness. However, to some extent roles are changing: there appears to be greater overlap between CPs and EPs following the 0-25 agenda and the inclusion of MH in the SEND Code of Practice (DfE & DoH, 2014); and commissioning of services continues to shift, increasing pressure on resources.

Various studies evidence difficulties in making changes to practice in complex systems of care, for example, Kauth, Sullivan, Cully, and Blevins (2011) investigate the process of health care systems attempting to implement evidence-based practices and guidelines; Edwards, Rowan, Marck, and Grinspun (2011) discover that it took decades for nurse practitioners to successfully integrate into the Canadian health system; and Frohm and Beehler (2010) consider the challenges faced by psychologists in changing chronic pain management, acknowledging the influence of medical culture and the power dynamics between psychology and medicine. Change tends to be a slow and uncomfortable process, leaving professionals feeling vulnerable and defensive.

Whilst improved communication between EPs and CPs will go some way to reduce tensions, both professions should exercise reflective practice to recognise their own biases and unhelpful preconceptions toward the other, and the wider system. Reflective, joint practice in both professions is essential in recognising that both services expect the other to provide work complementary to their own, whilst maintaining their own professional autonomy.

5.2.3.2 Summary

Through improving clarity of roles and working relationships, EPs and CPs may become secure enough to adopt more flexible approaches in supporting the MH of YPs in secondary schools. There will need to be a willingness of both parties to work together effectively, allowing negative biases to be tackled.

5.2.4 IMPLICATIONS FOR SUPPORTING SCHOOLS

The current study highlights the valuable role secondary schools can play in supporting MH. However, in previous literature, it emerges that school staff are often unclear what work professionals are carrying out with students (Squires & Dunsmuir, 2011) and schools are unsure where to make referrals when they have concerns (Madge et al., 2008). It is hypothesised that the confusion around roles evident in the current study is likely to affect school staff too. Greater clarity around professionals' roles and the routes for accessing services would improve schools' confidence in supporting MH of YPs.

The current study highlights incidences of school staff seeking to label difficult behavioural presentations, or misinterpreting indicators of MH difficulties as bad behaviour. Both scenarios could lead to less positive outcomes for the YP (De Wit, Karioja, Rye, & Shain, 2011). "Behaviour" is no longer acknowledged as an area of need in the recent SEND Code of Practice (DfE & DoH, 2014), and an insight into MH is increasingly important for schools. It is hypothesised that the unacknowledged discrepancies in professionals' constructs of MH furthers schools' confusion. More reflective and inclusive understandings of MH, modelled by professionals, are likely to support school staff's attitudes, perhaps improving the potential for "whole school approaches to promoting resilience and improving emotional wellbeing" (DoH, 2015, p.36).

5.2.5 SUMMARY OF IMPLICATIONS

Various constructs of MH, dependent on different epistemological positions, can be incorporated to enhance formulation. EPs, in particular, may need further training around MH difficulties in order to improve their flexibility in acknowledging approaches different to their own.

EPs and CPs could work together more effectively through improving their communication and reflecting on possible biases which reduce trust and cohesion between their services. Collaboration could be most effective if EPs and CPs work

flexibly, agreeing on joint formulations and goals for particular pieces of work. Furthermore, their skillsets are complementary, so different cases would naturally require different levels of input from the two services.

Schools would also benefit from improved clarity of: the EP and CP roles, referral pathways, and various constructs of MH. This would enable schools to identify more appropriate ways of supporting MH.

Evidently, these implications suggest time – a scarce resource – is necessary to enhance formulation and collaborative working. It may be argued, however, that any planned time investment is likely to improve efficiency in the future.

5.3 RESEARCHER'S REFLECTIONS

Charmaz (2006) suggests that researchers must scrutinise their "research experience, decisions and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher's interests, positions and assumptions influenced inquiry" (p.188). This scrutiny is now reported in order to enhance the validity of the research (Finlay, 2002).

5.3.1 AN AREA OF PROFESSIONAL AND PERSONAL INTEREST

As a trainee EP with a clinical background of supporting YPs with MH difficulties in both a NHS adolescent unit and a community base team, the researcher developed an interest in the perceived role of EPs in supporting the MH of YPs. The researcher was interested in the apparent avoidance of MH difficulties in an EP service which focuses on positive psychology and solution orientated practice.

5.3.2 IDENTIFYING PERSONAL BIASES AND PRECONCEPTIONS

Below are summarised potential personal biases recognised by the researcher:

- The researcher views the SDQ as lacking validity and encouraging a reductionist attitude to MH. This tool is recommended in the LA as a means of identifying appropriate referral routes, causing the researcher to feel wary about some of the

proposed practices in the relevant service. This reticence is acknowledged and held in tension with the more pragmatic view that a framework to support school staff and other primary care providers is necessary when making referrals without possessing expert MH knowledge.

- As a trainee EP, the researcher is not neutral in the process. The 'professional defensiveness' evident in the data is also experienced by the researcher, particularly at suggestions that supporting MH is outside of the EP's remit, and the EP should maintain a focus on psychometric testing. It is important to reflect on this feeling to avoid influence on the data analysis. Writing a reflective diary throughout the research highlighted to the researcher the possible impact of these emotive responses to the data.
- The researcher held her own construct of MH, developed through training and experience, making it difficult to adopt a neutral position. From a critical realist perspective, and having worked in an inpatient MH setting, she believes that there are specific diagnoses which cannot be entirely explained by environmental, socially constructed factors. Acknowledging these beliefs was particularly important during the data collection, avoiding leading questions during the semi-structured interviews. The pilot interview was helpful, allowing reflection with the participant afterwards, ensuring that the questions had not seemed weighted.
- The researcher, from a critical realist position, tends not to agree with the view that avoiding diagnostic categories would reduce stigma around MH. Rather, that a piece of work is enhanced by jointly agreeing desired outcomes, partly through acknowledging diagnoses and the medical understanding of MH needs. The researcher reflected on this position with research peers throughout the process, avoiding the data being influenced. It was also important not to give this perspective particular weighting in the discussion, without identifying if previous literature supported this approach.

5.3.3 AREAS OF PROFESSIONAL DEVELOPMENT THROUGH THE RESEARCH

Completing research is not a neutral process, inevitably the researcher is impacted, as is briefly explored now.

Throughout study, the researcher was struck by the subjectivity of the EPs' constructs of MH. Kelly (2008) suggests, "it is not difficult to see therefore why educational psychology faces a problem of role confusion when the processes which it seeks to influence are fluid, negotiable, subject to interpretation, without firm objective evidence and inevitably vulnerable to social control and power differentials" (p.23). The fluidity and ambiguity around the concept of MH was slightly frustrating to the researcher, who, having worked in clinical settings, was accustomed to more concrete concepts of MH. She was acutely aware of the limitations and flaws of clinical settings, but did not consider these factors to negate the reality that each YP objectively presented a set of symptoms.

However, through considering the ways in which the participants' views are formulated, the researcher realised that her own views were largely based on anecdotal experience, with minimal evidence based learning (Strasser & Gruber, 2015). In her early stage of training, the researcher realises that she holds a level of naivety in how practice can be carried out.

In considering the implications of the study, the researcher wondered which the *best* way of constructing MH was. She was helpfully reminded by her academic supervisor that there are strengths in *each* way of understanding MH, appreciating the richness of incorporating different ways of approaching the concept. Exploring how social constructionist and more positivist epistemologies can be complementary, and acknowledging the merits of developmental, systemic and attachment frameworks, was helpful. This process will be replicable to other areas of work in the future, enhancing the researcher's practice.

The experience of interviewing CPs provided excellent insight into their role, reducing uncertainty towards this service. As found through the current study, investing in understanding the perspectives of 'the other' increased the researcher's desire to work more closely with CPs in the future.

A final impact of the study was the process of discerning which details of the data to focus on, and which to 'let go'. The researcher has a tendency to hold on to all information, and struggles to identify the more pertinent insights over less relevant.

However, through the rigorous process of TA, she developed her skills in uncovering meaning from data, a skill useful in report writing.

5.3.4 THE RESEARCH JOURNEY

An initial interest in the support available for YPs' MH through secondary schools, and professionals' understanding of MH, led to a literature search of current provisions available in secondary schools. It is evident in the previous literature that assumptions are made around the constructs of MH, with no acknowledgement of the wide variety of interpretations. CPs are largely absent from literature, and the views of EPs unavailable, despite both professions being appropriately skilled and positioned to work with this particular client group.

In seeking to explore these unreported areas, a story of ambiguity and defensiveness emerges. It is perhaps surprising that two professions which are similar in many ways could experience such levels of misunderstanding – a discovery which could shed light on the limitations and frustrations expressed by school staff in previous literature. Developing a greater openness and collaborative understanding of roles may lead to more effective support of YPs' MH through secondary schools.

5.4 LIMITATIONS OF THE STUDY

Careful consideration of the credibility and dependability (Robson, 2002) is exercised throughout the study, however inevitable shortcomings are acknowledged below.

The sample of participants are from just one LA, meaning that the experiences of interdisciplinary working are subjective to the systems in that LA. Caution must therefore be exercised in generalising the findings to practice in other LAs.

As the participant groups are relatively small, the perspectives expressed are quite diverse. Larger participant groups may allow greater saturation in views, or possibly even greater variation. Additionally, the participants are self-selected to some extent, as a number of CPs and EPs were approached who declined involvement. It is possible, therefore, that the perspectives expressed in the data are those of CPs and EPs who hold particularly strong views which they wanted to share, or the views of EPs and CPs who

feel slightly more autonomy over their time than the psychologists who felt unable to participate.

Furthermore, the small population size made it difficult to obtain a non-biased sample, and the snowball sampling approach that utilised key informants to recommend possible participants may have led to a biased sample. Whilst the intention of the approach was to identify a range of professionals from relatively hard to access groups, it is possible that more 'isolated' perspectives within those groups were overlooked (Atkinson & Flint, 2001). Cohesion amongst the groups may also have been overemphasised, as only psychologists who are relatively well connected with other colleagues will have been recruited. This sampling method also reduced the anonymity of the participants, as those making recommendations will be aware that their recommended individual could be recruited.

An in-depth analysis of the different roles is not conducted, despite the CPs being from a range of different teams, some of which are not part of the health service. The subtleties of different systems are therefore not acknowledged in as much detail as they might have been. Greater detail about the nature of each participant's psychological training may also be useful: the diverse range of providers for both the EP and CP doctoral training will inevitably influence their trainee's epistemological and ontological positions, and the work they feel competent carrying out. However, it was not possible to explore all of the many different factors which will influence a professional's constructs in such a complex area.

A mixed method may have added to the findings through comparing the qualitative experiences of the participants with the number of years they have worked. This, however, would assume that the length of time worked in a particular area can represent the quality of a practitioner's experience.

The current research particularly focuses on practice in relation to secondary schools. However, the experiences of YPs who are not in mainstream education are not specifically considered. This group of YPs tends to be vulnerable, often accessing less support than YPs in the more established network of mainstream provision (Arnold & Baker, 2013).

Furthermore, the search terms in the systematic literature review maintained a focus on psychological input within a secondary school environment, perhaps missing relevant papers which link CPs to adolescent MH. The literature which was reviewed had a slight bias towards EP participants, likely due to the school emphasis.

Being a trainee EP reduces the neutrality of the researcher's role. Through reflecting on the impact of self in the research process, the researcher is aware that the CPs appear quite agenda-ed in their responses, possibly communicating frustrations in the hope that it could shift EP practice; *or* kinder, wanting to avoid offense. Whilst the researcher attempted to set the participants at ease, assuring them that their views would be held in confidence, both of the above attitudes seem to occur and a more neutral researcher may have gathered more representative views.

Although TA is a relatively robust and thorough approach, it is more limited in higher level interpretation. For example, Braun and Clarke (2013) acknowledge that TA lacks the exploration of language and possible meanings of the way the participants express themselves. The current study does not propose to explore the discourses of the participants, but certain aspects of the data could have been enhanced through discourse analysis, for example, understanding the ways in which EPs and CPs explain their constructs of MH (Smith, 2015).

The study is UK-centric. The scenario is very different in other parts of the world, for example:

> Children and youth in developing countries are most often entirely dependent on parents and other responsible adults for support in finding health services and treatment… This results in primary caregivers' attitudes and circumstances having a direct effect on their health and treatment of children in a more concrete and direct way than in societies where children's right to health care is more consistently enforced. (Bohlin & Mijumbi, 2015, p.280)

The current study is only representative of the challenges faced in the UK system, and specifically relevant to the experiences of 12 psychologists in one LA. However, some of the lessons learnt may be applicable in a wider context.

5.5 FUTURE RESEARCH

The current study raises a number of areas which could be investigated further to ensure that support around MH for YPs is most effectively offered.

Views are expressed in the current study around promoting MH in schools, psychologist availability for individual therapeutic support, and equipping school staff to be more aware of possible MH needs. However, previous literature suggests that YPs do not want to access these services (Kay et al., 2006). Presenting the findings of this study to YPs in secondary schools, to explore their willingness and capacity to engage with the different possible provisions would be useful.

Furthermore, EPs and CPs feel that schools have a valuable role in supporting MH, however previous literature suggests that schools are stretched and often ill equipped to fulfil those tasks (Rothì et al., 2008), and are unclear where referrals should be made (Madge et al., 2008). Future research could include a participant group of school staff, exploring their needs and expectations in working with practitioner psychologists, and understanding MH.

The current study focuses on supporting MH within a secondary school setting, not examining the provisions for YPs who are Not in Employment, Education, or Training (NEET). Future research could helpfully explore EP and CP understanding of their role in supporting these vulnerable YPs who lack the support of a school network.

It is evident in the current research that improved communication between EPs and CPs is important. Further research could explore ways in which they can most effectively overcome uncertainties around each other's roles. Potentially soft systems methodology (Checkland, 1999) could be used to explore the ways in which their joint practice is most effectively taking place, and areas of possible improvement.

The current study provides insight into how professionals construct an understanding of complex concepts, suggesting that a synthesis of experience and training is important. This could be investigated further to provide recommendations for future professional development. A mixed method approach may be helpful, acknowledging the nature of the training course and the number of years practiced. Furthermore, exploration of

professionals working together from different epistemological positions could be helpful in enhancing collaborative practice.

5.6 CONCLUSION

5.6.1 CONSTRUCTS OF MH

The current study identifies that EPs and CPs construct an understanding of MH through integrating experience and declarative knowledge (Charlin et al., 2007; Strasser & Gruber, 2015), leading to diversity in their understandings. Both professions draw on developmental frameworks. However CPs tend to have more experience of working directly with MH difficulties, and EPs of working to promote MH. This is evident in their constructs of MH, with EPs conveying less coherent understandings of MH difficulty, considering MH to be a subjective experience, whereas CPs have a more united construct of MH, seeing MH difficulty as enduring emotional distress. EPs appear to use a theoretical base to make assumptions about the aspects of MH which they have little experience of. Throughout the data, there is no reference to the DSM-V categories, and a shared concern that MH diagnoses may lead to reductionism and possible stigma. EPs and CPs tend to adopt a systemic approach to formulation, considering social and relational factors (Johnstone & Dallos, 2013).

Varying constructs of MH are considered by some to be problematic (Davies, 2014). However, where there is reflexivity and transparency, it is argued that different approaches can be combined to enhance formulation. It is suggested that diagnostic labels can provide a helpful summary for YPs and professionals, and if used with caution in combination with a more systemic approach, can bring further understanding and meaning to MH.

A greater appreciation of other approaches to MH may increase psychologists' flexibility in working with different professionals, and understanding the strengths of medication in combination with talk therapies. EPs lack unity over their understanding of MH difficulties. As it is increasingly relevant to the EP agenda (DfE & DoH, 2014) it may be important for EPs to receive further training in this area and the opportunity to reflect on their constructs of MH.

5.6.2 PERCEPTIONS OF ONE'S OWN AND THE OTHER'S ROLE

The current study finds that EPs and CPs have misunderstandings about each other's roles, for example, CPs think that EPs should be focusing on psychometric testing, and not working outside of their skill set by tackling direct work with MH; EPs feel CPs should be working more closely with schools and avoiding inflexible, deficit-focused service provision. These views appear to be provoked by negative biasing of the unknown, and professional defensiveness. EPs and CPs have a general awareness of the other, and a broad understanding of what the role involves. However, the lack of personal relationship leads to ambiguity and perhaps negative assumptions.

Furthermore both EPs' and CPs' jobs are constantly in a state of flux, causing them to feel some professional defensiveness about their roles, wanting to assert their professional boundaries, guarding their job remit to avoid losing any autonomy (Jones, 2006).

It is argued that trust and clarity of roles could be achieved through clearer communication and reflection on professional biases. Collaborative working could be developed most effectively through a transdisciplinary model whereby professionals work closely together with the primary aim of meeting the needs of the YP, identifying shared strategies and goals (Patel et al., 2008; Ritzema et al., 2014). Resources and skillsets would be pooled through this approach, increasing the potential for YPs' needs to be met when resources and time are limited (Bell et al., 2010; Hoeman, 2008). However, this approach to collaborative working requires high levels of job security.

5.6.3 SUPPORTING SCHOOLS

CPs and EPs think that schools have an important role in flagging up issues, being a 'safe base' for YPs, and in promoting MH. EPs and CPs do not feel that schools should be carrying out basic assessments and suggest that school staff should have further training around MH so as to differentiate between MH needs and poor behaviour.

MH is increasingly relevant on secondary schools' agendas. If schools are to play a role in supporting MH, it is hypothesised that they would benefit from greater clarity around the roles of different professionals, and appropriate referral routes. More collaborative

working between EPs and CPs is likely to improve communication with schools regarding the care of YPs.

5.6.4 FINAL THOUGHTS

The findings from this study are in keeping with national initiatives, such as *Future in Mind* (DoH, 2015):

> Effective access to support requires improved communication between universal, targeted and specialist services, backed by a clear shared understanding of roles and responsibilities across all those involved in the system, so that children and young people do not fall between services, and receive timely and appropriate support. (p.65)

Evidently, CPs and EPs are skilled and equipped to support the MH of YPs in secondary schools. However, resources are scarce, and poor working relationships could hinder effective joint working. Despite all the external constraints, by working together meaningfully, professionals may increase the quality of services for YPs and secondary schools.

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7. APPENDICES

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APPENDIX A: TRAIL OF THE SYSTEMATIC LITERATURE SEARCH

***Initial Searches, broadly investigating the literature**:*

Search Date	16th May 2015
Databases searched	Education Research Complete, PsycARTICLES, PsycINFO
Key words used	Psycholog*, school, mental health
Results	57, 364
Advanced search inclusion criteria	Peer reviewed journals; 2003-2015; English; adolescent age group (13-17);
Results	11, 545
Key words used	(Clinical Psycholog* OR educational psycholog*) AND mental health AND school
Results	2, 418
Advanced search inclusion criteria	2003 – 2015; peer reviewed journal; English; aged group: adolescence and school age (6-12 years).
Results	390
Advanced search inclusion criteria	Changed search to (Clinical Psycholog* OR educational psychology*) AND (mental health OR mental wellbeing) AND school
Results	1,906
Advanced search inclusion criteria	Added adolescent age group
Results	816
Comments	*At a glance, the articles are extremely varied – many are about the validity of assessment tools; none of them seem to specifically mention the psychologist*
Key words used	(Clinical Psychologist* OR educational psychologist*) AND (mental health OR mental wellbeing) AND school
Results	1, 036
Advanced search inclusion criteria	Peer reviewed; 2003-2015; English
Results	307
Comments	*These articles look MUCH more relevant but "mental wellbeing" too specific – could be missing some articles.*
Key words used	(Clinical Psychologist* OR educational psychologist*) AND (mental health OR wellbeing) AND school
Results	1, 036
Advanced search inclusion criteria	Peer reviewed; 2003-2015; English
Results	335
Comments	These articles are looking MUCH more relevant, but wanting professionals' perspectives.

Refining the Search Criteria

Search Date	21st May 2015
Databases searched	Education Research Complete, ERIC, PsycARTICLES, PsycINFO
Key words used	(mental health OR wellbeing) AND school AND (joined working OR

	joint working OR collaborative)
Results	2,000 +
Advanced search inclusion criteria	Peer reviewed; 2003-2015; English; adolescents
Results	592
Comments	*There are a number of articles coming up around the area of "joint working" and perspectives held on this, but still too many articles. That said, the majority don't fit the "research; in UK; professionals (not families) criteria…)*
Key words used	(mental health OR wellbeing) AND school AND (joined working OR joint working OR collaborative) AND (practitioner OR psychologist)
Results	143
Comments	*Too specific – wanting to hear the views of other professionals*
Key words used	(mental health OR wellbeing) AND school AND (joined working OR joint working OR collaborative) AND (practitioner OR psychologist OR CAMHS OR mental health services)
Results	223
Key words used	(mental health OR wellbeing) AND school AND (joined up working OR joint working OR collaborative) AND (practitioner OR psychologist OR CAMHS OR mental health services OR mental health worker OR child and adolescent mental health service*)
Results	259 (added peer review and removed adolescent age-group) it's now jumped to 970?!
Comments	*I'm now looking at the Boolean phrase – there are more ways of phrasing joint working.*
Key words used	(mental health OR wellbeing) AND school AND (joined up working OR joint working OR collaborat*) AND (practitioner OR psychologist OR CAMHS OR mental health services OR mental health worker OR child and adolescent mental health service*)
Results	2, 133
Comments	The list of included articles seems quite random now – lots of international studies.
Key words	(mental health OR wellbeing) AND school AND (practitioner OR psychologist OR CAMHS OR mental health services OR mental health worker OR child and adolescent mental health service*)
Results	28, 430
Key words	(mental health OR wellbeing) AND school AND (practitioner OR psychologist OR CAMHS OR mental health services OR mental health worker OR child and adolescent mental health service*) AND (joint working OR joined working)
Results	28
Key words	(mental health OR wellbeing) AND school AND (practitioner OR psychologist OR CAMHS OR mental health services OR mental health worker OR child and adolescent mental health service*) AND (challenge*) AND (research)
Results	1,541
Key words	(mental health OR wellbeing) AND school AND (practitioner OR psychologist OR CAMHS OR mental health services OR mental health worker OR child and adolescent mental health service*) AND (challenge*) AND (research) NOT (families OR family OR parent*)
Results	1,034
Comments	I've lost some of the most relevant searches now.

Key words	support* AND (mental health OR wellbeing) AND secondary school AND (practitioner OR psychologist OR CAMHS OR mental health services OR mental health worker OR child and adolescent mental health service*) AND (research) NOT (United States* OR Australia)
Results	59
Key words	(mental health OR wellbeing) AND secondary school AND (practitioner OR psychologist OR CAMHS OR mental health services OR mental health worker OR child and adolescent mental health service*) AND (research) NOT (United States* OR Australia) AND (perception* OR perspective* OR view* OR opinion)
Results	59
Comments	*This one seems to be getting more appropriate? Wanting to see the opinions held by those involved around the linking up of schools and mental health provision. Might highlight that there isn't much on the EP/CP perspective?*
Key words	(mental health OR wellbeing) AND secondary school AND (practitioner OR psychologist OR CAMHS OR mental health services OR mental health worker OR child and adolescent mental health service*) AND (perception* OR perspective* OR view* OR opinion)
Results	124 (104 after duplicates removed)
Key words	(mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion)
Results	344 (288 after duplications removed)
Key words	(mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion OR experience)
Results	541 (462 after duplications removed)
Key words	(mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion OR experience) NOT (United States OR Australia)
Results	325 (after duplications removed)
Comments	*Picking up relevant articles. Check some more data bases now.*

Appropriate Search Criteria Identified:

(Mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion OR experience) NOT (United States OR Australia)

Search Applied to other relevant data bases:

PubMed	(mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion OR experience) NOT (United States OR Australia)
Results	1025
Exclusion criteria	2003-2015; only humans; clinical trials, not reviews.
Results	462 *(13 relevant abstracts) 4 relevant articles after applying exclusion/inclusion criteria, and removing duplicates.*
British Education Index	(mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion OR experience) NOT (United States OR Australia)

Results	45 results
Advanced search inclusion criteria	2003- 2015; peer reviewed; English only
Results	40 results *(5 relevant articles; 1 after duplications from previous searches had been removed).*
Scopus	(mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion OR experience) NOT (United States OR Australia)
Results	367 results
Advanced search inclusion criteria	2003- 2015; peer reviewed; English only
Results	230 – *after scanning through the titles and abstracts for exclusion criteria, and removing duplicates, 3 further articles were found.*
Academic Search Complete	(mental health OR wellbeing) AND secondary school AND (perception* OR perspective* OR view* OR opinion OR experience) NOT (United States OR Australia)
Results	329 results
Advanced search inclusion criteria	2003- 2015; peer reviewed; English only
Results	279 – *all relevant articles had already been identified in previous searches, suggesting that saturation had been reached*.

- After these exclusion criteria had been applied, the results from each of the different search engines had been combined, and duplications had been removed, 916 articles remained.
- The titles of these articles were checked manually, and when appropriate, the abstracts were considered in order to apply a second wave of exclusion criteria. At this stage a number of articles were excluded which did not refer to mainstream secondary schools, did not mention the MH or EWB of students, did not involve the direct perspectives of individuals involved in this area, or were not conducted in the UK. Articles which assessed the objective success of a provision were also not included, as it is the *perspectives* held by those involved which were deemed relevant and useful. 27 articles were found to be appropriate; these abstracts were examined in greater depth applying the exclusion criteria once more, and the references were explored to identify any relevant papers which had, as yet, been overlooked.
- A final 20 research papers were identified.

APPENDIX B: A TABLE SUMMARISING THE RESEARCH PAPERS IN LITERATURE REVIEW CLUSTER ONE (INTERNAL SCHOOL STAFF SUPPORTING THE MENTAL HEALTH AND WELLBEING OF STUDENTS)

Author and Year	Main focus	Methodology	Partici-pants	Research understanding of 'mental health'	Key Findings
Haddad, M., Butler, G. S., and Tylee, A. (2010)	*Exploring school nurses' views concerning the MH aspects of their role, their training needs, and attitudes toward depression in students.*	*Quantitative design* Data Collection: *Questionnaires* Data Analysis: *ANOVA*	258 school nurses	Suggests a link between subjective well-being relating to psychiatric diagnoses, thereafter the study focuses on the nurses' views of "mental health problems".	93% of participants felt that MH is an integral part of their job, 55% felt that "young people's psychological problems" occupied more than a quarter of their work time, and 46% had had no post registration training in this area.
Kidger, J., Gunnell, D., Biddle, L., Campbell, R., and Donovan, J. (2009b)	*Exploring the role of teachers in supporting the mental health of secondary school students.*	*Qualitative design* Data Collection: *Semi-structured interviews* Data Analysis: *Thematic analysis*	14 school staff at eight secondary schools	Identifies three separate initiatives in schools: EWB, social and emotional aspects of learning, and developing models for YP experiencing MH difficulties.	Three themes emerge: 1) Teaching and EWB are inevitably linked; 2) Perception that some (other) teaching staff are reluctant to engage; 3) Teachers' own emotional health needs are neglected. Key implications: whole school approaches are important, including support for teachers; and a greater clarity around the meaning of EHWB is needed.
Timson, D., Priest, and	*The attitudes and knowledge of school*	*Quantitative design* Data Collection:	30 secondary	Focus on MH *issues*, discussing the	Teachers scored lowest in their perceived knowledge of managing self-harm and

H., Clark-Carter, D. (2012)	*teachers, A&E staff, and CAMHS staff regarding self-harm. Their training needs are considered.*	*Self-report, Likert Scales questionnaires* Data Analysis: *MANOVA (comparing the three groups)* *Pearson product-moment correlation coefficient (examining relationships between variables)*	school teachers 39 CAMHS staff 51 A&E staff	prevalence of different disorders co-existing.	their effectiveness of supporting this area. Teachers also felt most negative about self-harm. The 'perception of roles' was seen to impact the participants' willingness to engage with supporting this area of need.
Kay, C. M., Morgan, D. L, Tripp, J. H., Davies, C., and Sykes, S. (2006)	*Exploring YPs' health concerns, and their knowledge and views of school nurse drop-in clinics held in school*	*Quantitative design* Data Collection: *Cross section survey* *Two Questionnaires* *Secondary analysis of database* Data Analysis: *not stated*	590 11-17 year old students	MH and EWB are grouped together and identified as issues concerning relationships, friendships, anxiety, depression, self-harm and bullying.	MH and EWB were the main area of concern for the YP. Boys were most likely to talk to their parents about concerns, and girls would prefer to talk to their best friend. Only 7% of participants rated school-nurses as the person they would most likely to turn to for help, and 3% rated teachers. Issues with the drop-in were lack of clarity around when they happen, and concerns around a lack of confidentiality. However, 62% of students felt drop-ins were important, and amongst those who had *used* the service, 92%.
Partridge, K. (2012)	*Exploring pastoral staff's experiences of their own emotional well-being in a secondary school*	*Mixed method design* Qualitative phase: *Semi-structured interviews, IPA;* Quantitative phase:	6 pastoral staff	Reference to promoting 'well-being and health' in schools. The view is expressed that "implementing	Supporting YP in this area can be emotionally complicated for staff. Seemingly contradictory emotions may be evoked, and the experience appears to be different for different individuals.

		Personal Construct Psychology (PCP) using Repertory Grid interview, analysis not stated. Theoretical frameworks: *Psychodynamic and systemic perspectives* *Critical Realist*		individual interventions with pupils is not as effective as creating a whole school ethos where the environment shifts in attitude towards promoting emotional well-being" (p.122).	Recommendations are made around utilising supervision and understanding their own emotions through training around EWB. Promoting a supportive whole school ethos could be achieved through consultations, group work and training.
Madge, N., Foreman, D., and Baksh, F. (2008)	*Exploring the views of individuals working in primary care (including school staff) regarding "Comprehensive CAMHS" (CAMHS teams supporting primary care works to be engaged in the management and support of YPs' MH problems.)*	*Mixed methods design* Data collection: *Questionnaires* *Focus Groups* Quantitative analysis: *SPSS statistics* Qualitative analysis: *constant comparison procedure.* Theoretical framework: *none stated.*	150 primary care personnel (Questionnaires, n= 122; Focus groups, n=60)	This paper researches a service developed to "manage common MH *problems*", rating these difficulties in levels of severity, and adopts a medical model.	Primary Care workers feel that they need greater support and information on criteria for referral to CAMHS – this includes how to prioritise cases; when to make a referral; the process following a diagnosis; and working collaboratively with CAMHS.

APPENDIX C: A TABLE SUMMARISING THE RESEARCH PAPERS IN LITERATURE REVIEW CLUSTER TWO (EXTERNAL PRACTITIONERS PROVIDING INPUT IN SCHOOLS)

Author and Year	Main Focus	Methodology	Participants	Research understanding of 'mental health'	Key Findings
Atkinson, C., Squires, G., Bragg., Muscutt, J., and Wasilewski, D. (2014)	*EPs' experiences of using therapeutic interventions in their work.*	*(?) Mixed method design* Data collection: *Online survey (with postal vote option) – quantitative and qualitative responses*	455 Educational Psychologists	'Therapy' is defined here as "the treatment of mental or psychological disorders by psychological means".	There are systemic barriers to the EPs being able to carry out therapeutic interventions: schools are unable or unwilling to fund direct work, and clinical supervision is often unavailable.
Hamilton-Roberts, A. (2012)	*Teacher and counsellor perceptions of a school-based counselling service (SBCS).*	*Mixed method design* Data collection: *Questionnaire, focus groups & interviews* Data analysis *Quantitative data: descriptive statistics; Qualitative data: content analysis.* Theoretical framework: *systemic?*	4 school-based counsellors, 9 link-teachers (from 9 secondary schools)	Suggests that counselling "helps children and young people to experience emotional health and well-being, reducing the effects of emotional and mental health problems as barriers to learning. EWB and MH are referred to as separate concepts.	The counselling service is perceived to most impact the area of MH and EWB for the YP. It was difficult to quantify the impact of the SBCSs. Counsellors found that teacher perceptions of the presenting issues, and therefore the expected and desired outcomes, often differed from those presented by the pupils themselves.
Atkinson, C., Squires, G., Bragg, J., Wasilewski,	*An exploration of what's working for four EP Services (EPSs)*	*Qualitative design* Data collection: *Semi-structured interviews with*	4 PEPs, Unstated number of EPs	The assumption that "mental health needs" should be managed through therapeutic	Main barriers were: access to training, limitations due to the EPS service models, schools lacking awareness of the available services, and physical

D., and Muscutt, J. (2013)	*which claim to provide effective therapeutic practice.*	*Principle EPs, documentary analysis, interviews/focus groups.* Data analysis *Thematic Analysis*		support.	space available. Facilitators were seen as: Principle EP promoting approach, and supervision being available.
Osborne, C., and Burton, S. (2014)	*Assessing the effectiveness of EP supervision for ELSAs.*	*Mixed methods design* Data collection: *Questionnaires* Data analysis: *Descriptive statistics* *Thematic analysis*	270 ELSA	The researchers do not explicitly suggest a position, however the ELSA project aims to support pupils' emotional literacy.	ELSAs generally feel that their needs are met through the EP supervision – valuing good relationships, other group members, chances to discuss cases, share ideas and problem solve.
Squires, G. and Dunsmuir, S. (2011)	*Exploring the experience of TEPs endeavouring to integrate their CBT training into practice.*	*Qualitative design* Data collection *Focus Groups* Data analysis *Iterative process of qualitative analysis, using ATLAS computer programme* Theoretical framework: *analysis within the Lancaster Cycle of adult learning.*	24 TEPs	No clear definition is offered, however Social and Emotional Aspects of Learning is referred to as a way of promoting children's management of feelings, behaviour and cooperation with others; and it is stated that there are "many CYP who need intervention to improve emotional wellbeing, mental health and resilience" (p.117).	Various barriers and facilitators were found. Barriers: - No clear structures in place, following the intervention. - No confidential space in schools. - Schools not wanting to use their EP time on this. - Possible negative impact on school attendance. - Queries around level of CBT training. - Difficulties in accessing supervision. - Lack of clarity around professional territory. Facilitators: - Flexibility and supportiveness of EPS.

Rothì, D. M., Leavey, G., and Best, R. (2008)	*Examining teacher's perspectives on working with EPs to manage pupils with MH difficulties.*	*Qualitative design* Data collection: *Interviews* Data analysis: *IPA - "grounded in the data rather than being theory driven"*	30 teaching staff (head teachers, SENCOs, class teachers).	A link is made between Emotional and Behavioural Difficulties (EBD) and MH difficulties and the appropriate response is assumed to be "therapeutic intervention".	There is a shortage of EP time and resources, meaning that they are unable to see individual children, and it is not possible for relationships to be built over time. There is a greater need for continuity.

APPENDIX D: A TABLE SUMMARISING THE RESEARCH PAPERS IN LITERATURE REVIEW CLUSTER THREE (WHOLE SCHOOL APPROACH)

Author and Year	Main Focus	Methodology	Partici-pants	Research understanding of 'mental health'	Key Findings
Aston, J. A. (2014)	*Exploring the adolescent views about mental health promotion in secondary schools, using an ecological model to map the findings.*	*Qualitative design* Data collection: *Focus groups (semi-structured questions)* Data analysis: *GT analysis* Theoretical framework: *Constructionist; ecological model*	26 adolescents	Clear distinction between MH promotion and prevention; specifically researching the former; suggesting that schools need to be more involved in fostering health, social and emotional development, through improving whole-school environments. Reference to "positive mental well-being" reducing the risk of "mental disorders".	For schools to promote MH, society and school communities need to provide active listening cultures and an inclusive ethos. Adults need to have knowledge and understanding of child and adolescent development, identity and the importance of relationships.
Kidger, J., Donovan, J. L., Biddle, L., Campbell, R., and Gunnell, D. (2009a)	*Surveys used to quantify current levels of emotional health provision in English secondary schools; an exploration of how staff and students view current school-based emotional health*	*Mixed method design* Data collection: *Quantitative survey;* *Qualitative student focus groups and staff interviews*	296 Secondary Schools (for survey); 154 students aged 12-14 (27 focus	Makes a distinction between promoting "emotional health" and preventing "emotional disorder", claiming that "whole school approaches focusing on promoting good emotional health are more effective than stand-alone classroom-based	Three suggested areas where schools did or could intervene: emotional health in the curriculum; support for those in distress (this provision varied greatly in type and quality); and the physical and psychosocial environment (including addressing bullying or poor teacher-student relationships).

	provision and what they would like to see in the future.	Data analysis: *Descriptive statistics; TA* Theoretical: *implied systems model.*	groups); 15 staff interviews	interventions that aim to prevent emotional disorder" (p.2).	A further finding suggests that if support for distress were offered in school, it must be confidential - students voiced concern that accessing this would lead to stigma.
Raynor, S. and Wylie, A. (2012)	*Investigating differences in the presentation and management of bullying in two schools, one in an area of high deprivation, the other an area of low deprivation. Pupils' views explored.*	*Quantitative design* Data collection: *Web-based questionnaire* Data analysis: *Statistical analysis*	304 pupils from year 8 in four secondary schools	Bullying is reported as having a direct effect on the health and well-being of children and YP; referring specifically to self-harm and suicide in this paper.	Deprivation had no impact on the prevalence of pupils involved in a bullying culture. School policies around bullying need to be more accessible and possibly more focused on tackling the way in which young people *respond* to bullying.
Coombes, L., Appleton, J. V., Allen, D., and Yerrell, P. (2013)	*Examining young peoples' perspectives on emotional health and well-being (EHWB) in the context of secondary education, with a focus on the EHWB curriculum.*	*Qualitative design* Data collection: *Focus groups* Data analysis: *TA*	Year 10 pupils from five different schools (n=?)	Acknowledgement that there is little consensus about what MH means; but suggests that good MH is part of the wider concept of MH, encompassing the promotion of positive MH and also the tackling of MH difficulties.	Pupils felt that MH topics were neglected in the curriculum, especially in relation to self-harm. Three problems were identified in talking about MH: the quality was very dependent on the teacher's enthusiasm, pupils were concerned about confidentiality, and pupils often prefer to talk to their friends.

APPENDIX E: A TABLE SUMMARISING THE RESEARCH PAPERS IN LITERATURE REVIEW CLUSTER FOUR (JOINT WORKING BETWEEN EDUCATION AND HEALTH)

Author and Year	Main Focus	Methodology	Participants	Research understanding of 'mental health'	Key Findings
Vostanis, P., Taylor, H., Day, C., Edwards, R., Street, C., Weare, K., and Wolpert, M. (2010)	*In seeking to promote joint working between CAMHS and schools, this study aims to explore how much CAMHS staff know about educational issues and whether this came from training and/or professional experience.*	*Quantitative design* Data collection: *Questionnaires (scaled and open ended questions)* Data analysis: *Descriptive statistics*	96 staff from four specialist CAMHS	The research topic is justified through outlining the links between MH disorders and poor academic outcome.	Concerns are highlighted around perceived levels of knowledge and the ability to work with schools. CAMHS workers' attitudes towards school also impact their ability to work effectively in this context.
Hunter, A., Playle, J., Sanchez, P., Cahill, J., and McGowan, L. (2008)	*Exploring the perspectives of CAMHS workers and secondary school staff regarding the introduction of MHLW.*	*Qualitative Action Research* Data collection: *Focus Groups* Data analysis: not stated	15 education staff 11 CAMHS workers	MH is considered in terms of "disorder", and the schools' role is referral and identification. CAMHS workers are understood to manage "case work".	MHLW are seen to improve communication and to encourage mutual understanding between services. Potential barriers identified: different terminology used by education and health staff; problems in information sharing/confidentiality; different management causing disjointedness.
Van Roosmalen, M., Gardner-Elahi, C., and	*An exploration of the service model underpinning a Tier 2 child MH service, offering*	*Qualitative design* Data collection: *Semi-structured*	7 'Clinicians' (interviewed regarding 18 clinical	MH is referred to as something which can be "promoted", acknowledging that	A systems relations model emerged, suggesting that the Tier 2 Clinicians worked in schools at different systemic levels. Their role involves:

Day, C. (2012)	*school-based mental health work.*	*interviews* Data Analysis: *GT* Theoretical framework: *System relations model*	cases)	universal interventions in schools can prevent and intervene early in "mental health". Consultation delivery and systemic approaches are seen as positive.	1. Direct and consultative activities, including screening for MH issues; 2. Targeted systems work focusing on the YP's difficulties in different systems. 3. Universal systems function, improving the schools' overall approach to student MH through staff training and supporting the school to develop a mentally healthy environment.
Vostanis, P., O'Reilly, M., Taylor, H., Day, C., Street, C., Wolpert, M., and Edwards, R. (2012)	*This study considers the perspectives of child mental health and education professionals regarding joint working and training, including a preliminary evaluation of a training programme designed to bridge this gap.*	*Qualitative design* Data collection: *Semi-structured interviews* Data analysis: *Thematic analysis (using NVivo)*	Interviews: 31 CAMHS staff; 5 educationa-lists	The focus of the training evaluated is supporting the "early detection of education-related MH problems". The term 'EWB' is used interchangeably with 'MH'.	It is agreed that there is a training need in this area, but whilst health participants considered a degree of knowledge in education matters to be important, they felt that a relationship with education professionals was equally, if not more, important. They felt that knowledge could be developed through setting up link posts and joint training.

APPENDIX F: TIME LINE OF THE CURRENT RESEARCH

Phase One (July 2014 – May 2015): Planning and Preparation

- Literature review of the research area and familiarising with the local context.
- Formulation of research objective.
- Discussions with colleagues around feasibility and relevance of topic area.
- Gaining ethical approval through UEL Ethics Committee, and applying for Research Registration.
- Meeting with CP contact to discuss potential CP participants
- Preparation of Consent Letter; Participant Invitation Letter; and Interview Schedule.

Phase Two (April 2015 – June 2015): Research Implementation and Data Collection

- Pilot interview with EP colleague
- Recruiting participants through distributing Invitations and Consent Letters.
- Agreeing dates and locations for interviews.
- Completing interviews.

Phase Three (July 2015 – October 2015): Data analysis and interpretation

- Transcribing of data.
- Initial coding of data.
- Axial coding.
- Development of themes.
- Colleague coding of data sample to check for consistency.
- Development of theory.
- Checking findings with participants.

Phase Four (October 2015 – March 2016): Final Report Writing

- Anonymised summary of findings disseminated to participants.
- Final overall thesis written and submitted.

APPENDIX G: PARTICIPANT INVITATION LETTER AND CONSENT FORM

Participant Invitation Letter

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator:
Rebecca Miller
Email: u1326690@uel.ac.uk
Mobile phone number: 07912 596988

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the necessary information to consider, in deciding whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Educational and Child Psychology at the University of East London.

Project Title:
An exploration of Clinical psychologist and Educational psychologist constructs of mental health in the context of secondary school aged children.

Project Description: This research will be looking to explore the successes and challenges in supporting the mental health of secondary school aged children, with a particular focus of the role the Clinical and Educational Psychologist. Participation would involve one semi-structured interview lasting one hour, during which we would discuss topics such as your experience of working with adolescents regarding their mental health needs; your understanding of "mental health"; practice which you have found to work well; your perspectives on your own role and the role of others involved in this area.

The research hopes to identify areas of strength in joint-agency working, and possible discrepancies in the understandings held of mental health and/or the different job roles in this area. Themes which emerge will hope to inform future practice.

Practicalities: The location of the interview would be agreed between yourself and the researcher, endeavouring to find a venue both convenient, and allowing for an appropriate level of confidentiality.

Confidentiality of the Data: The audio recording of the interview will be deleted immediately after the data has been transcribed. The transcribed data will be anonymised, using pseudonyms and omitting any place names, team names or service details which might associate the data with you, as a participant. In transcripts, only first initials will be used. These transcripts will be kept on an encrypted memory stick for future analysis.

Your name and contact details would be stored on an encrypted memory stick, and kept until a decision has been made regarding the publication of the research – in this instance, you would be contacted to inform you that the agreed anonymising has taken place, and the details of the publication will be shared with you.

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw after the interview has been transcribed, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions, at any stage. Please retain this invitation letter for reference. If you are happy to continue, please sign the consent form attached and return to: Rebecca.miller@s[redacted] OR FAO Rebecca Miller, [redacted]

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [Helena Bunn, School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: h.bunn@uel.ac.uk]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in advance.

Yours sincerely,

Rebecca Miller, 28th January, 2015

Consent to participate in a research study

UNIVERSITY OF EAST LONDON

Title: An exploration of Clinical psychologist and Educational psychologist constructs of mental health in the context of secondary school aged children.

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to non-anonymised data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw after the data has been transcribed, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

……..

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: ……..

APPENDIX H: SEMI-STRUCTURED INTERVIEW SCHEDULE

Opening queries:

- *A brief summary of current job role?*
- *Length of time in current role?*
- *Previous job roles? Were these in the same or a different local authority (no need to provide details of this).*

(RQ1) How do Clinical Psychologists and Educational Psychologists construct "mental health"?

WHAT ARE THEIR VIEWS OF MH:

- ***Could you give me a brief summary of what you understand by the term "mental health"?***
    - (Prompts) Are "mental well-being" and "mental health difficulties/illness" perceived to be on a continuum?

HOW HAVE THEY BEEN SHAPED:

- ***What would you say has influenced the understanding you hold of mental health?***
    - (Prompts) Has this view been shaped by epistemology; training; or experience (personal or professional)?

VIEWS OF IT BEING PERCEIVED DIFFERENTLY:

- ***How helpful do you consider "mental health diagnosis" to be?***
  OR
- ***How helpful do you consider "the promotion of mental well-being" to be?***
    - Gaining an idea of how firmly they hold their view, and how well it has been thought through.

(RQ2) What are Clinical Psychologist and Educational Psychologist's practices in working in the area of mental health, related to secondary school aged children?

I'm interested in your role as an EP/CP working with the adolescent/secondary school age group – this could be direct work, or indirect. Feel free to use examples, but equally, hypothetical responses are fine.

NATURE OF EP/CP MENTAL HEALTH INVOLVEMENT

- ***What role would you consider yourself to have in supporting the mental health of adolescents?***
    - Would they see themselves as having a preventative role/promoting well-being/or treating difficulties? (prompt them to consider this)
    - Are there certain areas of MH they consider to *not* be their remit?

WORKING WITH SCHOOLS:

- ***Would you anticipate working directly with schools/teachers regarding the mental health of adolescents?***
    - Do they see this as their own role?
- ***What experience have you had of working with teachers in this area?***
    - Do teachers seek their expertise in this area?
    - What is the referral pathway?

CONFIDENCE OF WORKING IN THIS AREA:

Research suggests that this is an area where both EPs and CPs would like more training…

- ***What would you say has best equipped you to work in this area?***
    - Do they base their practice in experience or training or an evidence base?

(RQ3) In what ways do Clinical Psychologists and Educational Psychologists have a shared understanding of their different roles in the area of mental health, related to secondary school aged children?

ROLE OF TEACHERS:

- ***What role do you think teaching staff should have in supporting the mental health of secondary school aged children?***
    - Should they be trained to be involved/taught to make referrals/manage certain areas of mental health? Or have nothing to do this is?
- ***Is this the role that you have experienced them to have?***

ROLE OF THE "OTHER" (CP/EP):

- ***What role do you think that CP/EP's have in working with the mental health of secondary school aged children?***
    - Encourage them to answer according to their concept of "mental health".

JOINT WORKING:

- ***What experience have you had of working jointly with CP/EP?***
    - Can be quite general, but good to clarify positives and challenges of this experience.

APPENDIX I: SAMPLE OF INITIAL DATA CODES

CP3: RQ1 (How do Clinical Psychologists construct MH?)

Line	Raw Data	Initial Code
160	**I:** So could you give me a brief summary of what you understand by the term 'mental health'?	
162	**R:** What I understand by the term 'mental health'. Well I think	
164	it's anything to do with your kind of emotional world and your emotional wellbeing. It's on a continuum…it's probably	*Everyone has MH*
166	very subjective …umm…so its…umm…you know… someone might consider themselves having good mental	*On continuum*
168	health which I, you know, I would think would mean they feel good about themselves, they have good well being,	*Subjective experience*
170	good self esteem, they feel positive about things, they are generally happy, that kind of thing, they are in tune with	*MH equates to happiness*
172	their umm their emotional life, their experiences and so on. I guess at the other extreme you have people that are	
174	severely distressed, for whatever reason and that can show itself in lots of different ways, from sort of psychosis to very,	*Distress leads to MH difficulty*
176	very low mood to suicidal thinking and attempts and, you know, I am sure there's some sort of biological component	*Confident perspective*
178	to it all, as well as that sort of felt umm emotional component and social component.	

APPENDIX J: A SAMPLE OF THEME DEVELOPMENT ACCORDING TO BRAUN AND CLARKE'S (2006) PROCESS OF TA

Developing themes for RQ1: How do Clinical Psychologists construct mental health?

Raw Data	Initial Code	Sub-theme	Overarching theme
"parents needing to, you know, we are their safety figures, you know and people shouting and being horrible to their children(…) certain basic things can be really damaging" (CP5, L.281-284)	*Impact of confusing parent-child relationships*	Families and attachment impacting MH	[CPs construct MH] Within a Developmental Framework
"enabling that young person to create their own secure attachments and be a secure attachment figure is actually a really important role" (CP6, L.398-400)	*Learning attachment styles important*		
"I think parental well-being and their own experience and the impact of that is also a huge factor, and so I think you can do work at an early age" (CP6, L.374-377)	*Importance of parental support*		
"15 to 24 year olds probably are the peak period for people to develop that kind of…umm… that kind of difficulty" (CP1, L.549-591)	*Biological developmental considerations*	Developmental significance of being an adolescent	
"the remit of what is regarded as wellbeing for a young person is- is less than it is as an adult, umm, so(…) if you measured that person in terms of their mental health in one context would be seen as ok, but you change those variables in terms of their age(…) it would be seen as *not well*" (CP6, 235-240)	*Cultural expectations on adolescence*		
"you could probably talk to 100 adolescents and identify in their narratives examples of erm worry, insecurity, erm avoidance, erm and so it's almost a normal experience of adolescents" (CP2, L.450-453)	*Not medicalizing normal adolescent emotions*		
"I think with young people, because they are so much more entwined in terms of the context in which they're expected to live" (CP6, L.232-234)	*Impact of the environment at developmental stage*	Working with systems around adolescent	
"I think that's the key piece in understanding and working with an individual and their family, you know, you are going to really work with their family as well" (CP5, L.236-239)	*Family significant at developmental stage*		
"particularly when you are working with young people that you knew, it often means that you are involving other young people, other people" (CP3, L.317-320)	*Other YP significant in the adolescent system*		

APPENDIX K: TRANSCRIPTION INSTRUCTIONS

UNIVERSITY OF EAST LONDON

The Principal Researcher:
Rebecca Miller
Email: rebecca.miller@[redacted]

Project Title:

An exploration of Clinical psychologist and Educational psychologist constructs of mental health in the context of secondary school aged children.

Background to the research:

There is a growing emphasis on schools to acknowledge and manage the emotional wellbeing and mental health needs of children and young people. Legislation, policy documents and public funding reflect this shift, and yet literature in this area suggest that there are significant ambiguities in how this service provision is to happen. One of the most fundamental issues appears to be the lack of clarity around what "emotional wellbeing" and "mental health" actually mean. As a result, professionals are uncertain what is expected of them, and what successful outcomes should look like.

The purpose of my research is to consider ways of overcoming these ambiguities in order to provide a more coherent support for young people within the secondary school context. This will be achieved through conducting a number of in-depth interviews with Clinical and Educational Psychologists, exploring their experiences and perspectives of mental health, their own job roles, and the job roles of other professionals.

Due to the personal nature of this research, you will be required to sign a Confidentiality Agreement which confirms that you will adhere to the principles of anonymity and confidentiality and will not speak about the content or nature of the interviews to anyone apart from myself.

Theoretical Approach: Verbatim Transcription

This project requires **full verbatim transcription**. In brief, this means that as well as preserving the actual words which were spoken, extra verbal material captured on the recording – such as the speaker's use of intonation, pauses, rhythm and hesitation – should also be preserved. This keeps some of the additional meaning that was conveyed in the original interview, thereby

providing contextual information as to the manner in which words were spoken. In addition, verbatim transcription requires that the character of the conversational exchange is apparent, so the words of the researcher must also be included.

General notes:

- Please insert page numbers at the bottom of each page.
- Please identify the interview and the respondent separately. Use I: for interviewer and R: for the respondent. For example:

> I: Thanks for chatting me today. Please could you introduce yourself?
>
> R: Sure, my name is…
>
> I: Great, and could you describe your current job role?

- Please include what the interview says, with the one exception of 'back channel utterances', i.e. where I can be heard in the background saying words such as "right", "yeah" or utterances such as "mmmhmmm" whilst the interviewee is speaking. I tend to do this a lot, in order to encourage the respondent to continue speaking and reassure them that they are being listened to. It is not necessary to break up the respondent's speech by including them. That said, I occasionally get excited and say things like "oo, interesting!" in such a way that might then shape the response of the respondent. If this seems to be the case, please do include my "utterance". I appreciate that this is likely to be a matter of opinion so please do use your own discretion.
- Please use punctuation as for normal written prose. Grammar should not be altered or "tidied up". Please do not use 'eye spellings' (e.g. "enuff" for "enough").

Things to include in full:

- Unfinished questions or statements that trail off – please indicate these with ellipses (…), for example: "I'm really not sure why I did choose to go down that route, or what the alternative would have been, perhaps…"
- False sentence starts
- Repeated phrases, words, statements or questions
- Discussion that continues after the interview appears to be 'formally' finished
- Non-lexical utterances or 'fillers' such as 'umms' and 'errs' and 'uhs'
- Hesitations and Pauses – please indicate these with ellipsis (…), for example: "why do I think that… well… let me think… umm…"
- To indicate an exclamation of surprise, shock or dismay, please use the standard exclamation mark
- Emphases – indicate any emphasis on a word or phrase by putting it in italics.

Things to include in brackets:

- Noises in background – for example: (loud banging) or (door slams) or (muffled voices)
- The tone of the respondent. This will again need to be at your discretion - I don't anticipate there being many changes in tone, but where it seems relevant it would be great if you could include any comments on mood, feeling, passion, emotion and

paralinguistic – for example: (laughs loudly) or (mumbles slowly) or (sounds angry) or (sighs) or (falters slightly)

- Unclear words or phrases must be marked where they occur within the text by placing the word "inaudible" in brackets and in bold, e.g. (**inaudible)**. Please do not guess at anything which you cannot understand.

After Transcription

When you have completed transcribing an interview, please email it to me at Rebecca.miller@[redacted]. On receipt of the transcript, I will confirm that you can then delete and destroy both the interview recording and the interview transcript.

If there are large parts of the recording which you cannot understand or decipher, then please contact me immediately. Likewise, if you are concerned with any aspect of the transcription or these guidelines are unclear, then please do not hesitate to contact me on [redacted] or at Rebecca.miller@[redacted]

Thank you so much for agreeing to take part in this research project.

Yours sincerely,

Rebecca Miller

APPENDIX L: EXAMPLE OF INTERVIEW TRANSCRIPTION

I: Right…so XXXX, if you wouldn't mind just before I start with my questions, if you wouldn't mind introducing yourself and just telling me a little bit about your current job role and…

R: Okay, would you like to know a bit about my background?

I: Yes, that would be lovely

R: Okay…so, my name is XXXX XXX and I'm a Community Educational Psychologist at XXXX. I started out as a teacher and taught for 10 years…err…in a sixth form college in XXXX, and then I did…I did a completely different degree to start with and then I did a psychology degree with the XXX University and moved to XXXX Counselling Organisation in XXXXXXX and worked there. I moved out of teaching because I was much more interested in them as people than getting across my subjects

I: Okay

R: I knew I would do it sooner or later…and from there after my err psychology degree I went to the XXXXXX XXX in London and I did a Masters in Developmental Psychometric Psychology…umm…with the thought of becoming a child psychotherapist, so that was my interest, but it was just a bit tricky with young children and all that kind of stuff, so I didn't pursue the therapeutic training, but I have a Masters from there. Then I decided out of… almost like a too clinical or educational psychology… (laughter). I made a very pragmatic decision because again my boys were about…I have to think how old they were…they probably were about six and four, and at the time educational psychology training was a year, clinical was three umm and…umm, yes and I thought…and also I thought there were lots of opportunities in educational psychology to be a proper community psychologist, and that appealed to me and was kind of *breadth* of things that I could do. So I did that but...so I did that but always bearing in mind that my interest lay in mental health…that was *always* my interest in psychology…umm… Then I worked for XXXX for a couple of years, then a specialist

post in early years educational psychology came up in XXXX and I took that, which initially meant training the…managing the portage team, but I took the early years bit and created an infant mental health post out of it (laughter). So I had done lots and lots of work in that area that I won't tell you about unless you want me to

I: Oh…well…no, I will ask you really quickly. So you specifically decided to make this…this role in infant mental health

R: Yes

I: Where did that idea come from…was it…?

R: Well it came from me and think...because it's the thinking that instead of doing…because I believe whole heartedly that many, many problems can be avoided or…umm…made a lot…umm…smaller (laughter)… say by appropriate intervention early enough…umm… I mean I guess I am someone who sees that… most of the

difficulties that we see as educational psychologists later on in primary and secondary school could have been either avoided completely or just sort of ameliorated massively and I mean…and I am including all the young people with learning difficulties and physical difficulties…everyone… Things could be made a lot better if the relationship at home was sound and the relationship initially and then relationships at school were the best possible kinds of relationships and people were really tuned into the children

I: Okay, and when you say 'these problems that could be avoided' is that…what do you mean by that?

R: What do I mean by that…okay…so I mean umm...the kinds of things that we get called in for where umm…particularly late primary and secondary… where a young person err doesn't have friends or has got caught into very negative err relationships umm…with others where they…their learning has come to a halt or going backwards…umm…where there just seems to be a complete breakdown and they don't…they are very passive or have a sort of helplessness to them…they don't

have much hope about themselves…sort of the whole gamut…so cognitively not doing well, emotionally not doing well, mental health is awful, you now, err…peer groups awful…so everything is poor, and I believe very strongly that *all* of those things could be… very much either avoided or improved by early enough help of the…of appropriate kind

I: Okay…okay…I think I'll…going to scribble a note to myself that we will come back to that 'the early help of an appropriate kind'…and just before we move on from your introduction…describe quickly for me what your actual role is like at the moment

R: At the moment…?

I: Well…post…is there another…?

R: I'll do post a little bit just because I work…I've got a very, very…highly specialised role at the moment…so... In…as my early years' role…so apart from portage I...umm…so I

delivered attachment training to children's centres…umm…I…umm…I was kind of like getting…trying to get people together to think about infant mental health. I ended up umm chairing err XXXX Regional Perinatal and Infant Mental Health Networks for six years…so that's a cross professional group of getting together and sort of seeing how we could intervene more helpfully together

I: and that was…is that ongoing now…?

R: No…no…these things came to a stop last September. So I was doing lots of sort of specific bits like that…err…and then I was umm…I suppose I particularly took on a lot of early years work and thought…I was part of an early years' specialist group in the service…the EP service, so we met together to think about how to make EPs more accessible for settings…you know…how to provide a more direct and better EP service for pre-school children. So there was lots of sort of strategic (inaudible) umm…and then also I had… I had like 10 schools where I did sort of ordinary work

I: in your spare time!

R: In my spare time

(laughter)

R: and alongside that I trained in something called video interaction guidance

I: Yes!

R: and…so you see…you have heard about… you know about video interaction guidance…?

I: Yes…yes

R: Yes…so since September I've…I keep reducing my hours… My hours are very reduced now to a day and a half a week and I…it's all video interaction guidance basically, so I supervise others in this service (unaudible) service. I run the practioners' group and I organise an annual conference, I organise intervisions, peer intervisions… umm… and I deliver two infant mental health interventions, using video interaction guidance (laughter). So one is with mums with postnatal depression and their infants, together with colleagues in a children's centre, and the other is a antenatal intervention where we visit the mum, the family, antenatally, and look at development, attachment, all that kind of thing and then do video interaction guidance after the baby is born…so, I do that

I: Wow!...that sounds really fascinating!

R: Yes…so it's…so, I mean… it's a bit of a highly specialised role (laughter)…

I: So you have kind of found your…sort of…real point of interest and pursued it

R: Yes…yes. So it's a bit unusual what I do really, but the Service has been supportive in that, you know, if I am using psychology to help, you know, vulnerable people and…so some of…one of the mums I see at the moment is 17, and so she fits into all categories….(laughter) …of our work

I: Okay, well I will bear all of that in mind as we plough on with my questions. So the first section of the interview is specifically around your *personal* views on mental health. So I'll kick off just with the very broad question, Could you give me a brief summary of what you understand by the term "mental health"

(laughter)

R: Okay…so I suppose if I had to define mental health it would be a state of err good enough functioning…that

covers the emotional and mental functioning of us…umm…so…I don't … Mental health is something that I see regards us all, and we all have fluctuating states of mental health…umm…and I don't see such a big divide between myself as a professional and the client. The difference is that I have better coping mechanisms than them I would say. So I don't see myself as the umm…I don't see myself as the expert, and I prefer a more collaborative approach

I: Collaborative with the client or….?

R: With the client…yes…because I don't see…umm… If you read a lot of the theory, which I obviously have, you know, you can think there is this sort of perfect state of mental health which we should all aspire to. I disagree with that view, I think a lot of us have quite a bit of dysfunction about us, you know, a lot of us human beings…most of us…all of us have… their level, and it's about how much it intrudes upon our life, and what barriers does it present to us. So I don't see…umm…I suppose, you know, for me worrying poor mental health is where the barriers are really getting in the way of that person's err… well

functioning. It's difficult to choose words really that don't go to the well being and stuff like that, but it's about, you know, can you…can you sort of do what you need to do in life in a…in a reasonably good enough, happy and fulfilling way… and I think there is room for lots of dysfunction with it…within that…err…but it's about how people manage it

I: Okay…and you are trying to avoid the term 'well being'…what does well being mean to you?

R: Well (laughter) it's kind of like another thing to define isn't it?... and so I kind of…well you know… What do you mean by well being?…it's kind of err, I don't know, a sense of err…contentment? I don't even like (inaudible) (laughter) flat term. I like the term 'good enough' because it (inaudible) about, **'**Are you getting…' err… 'Is there good enough satisfaction in your life?' 'Is the 'good enough' kind of levels of happiness and calm and…', you know, 'Are your…are your…relationships with other people…do they feel good enough, and are they satisfying enough?' ….and so what is *enough* for me could be a bit relative, because for one person who has had extremely traumatic relationships…'good enough' for them might be at a lower

level than for someone else who's used to good err much higher level let's say…and therefore if it dips…if it becomes 'just adequate' they can be in a state of acute suffering…so I think it's all a little bit relative

I: Yes…no…that's very interesting…and the idea of wellbeing…you are talking a lot about kind of relational stuff…

R: I think it's… for me it's all about relationships…it's all about relationships. The relationships are the *core* to us being umm happy and fulfilling our potential…because…because we all…because of everything I believe in and the theories that I've read... It's about that we are hard wired to interact with others, and when those interactions are satisfying and we feel tuned in to…we're seen by others and we….initially, you know, our needs are met and we can learn how to interact with others…then we have a sense of satisfaction that goes…that can go beyond a lot of other awful things. So that's why for me, you know, people in very traumatic circumstances, what can anchor them in life is a strong relationship…and the theory around post traumatic stress

disorders, that the only thing that really helps people with post traumatic stress disorder is a strong attachment with a significant other or others in their lives, it's the only thing that seems to help

I: and so…just to clarify… for when I am going through my transcriptions…are we talking about wellbeing and this concept of mental health as being two separate entities or are they very much overlapping? Are they on a continuum? How do they…?

R: I will have to think about that….

I: Yes do.

R: Umm…what I think is…if you have umm (inaudible) experience err a classified disorder say…let's say that someone has got bipolar disorder…okay?

I: Yes

R: So they have a…that's a significant challenge let's say, to… to their mental health or mental…health or wellbeing. So…what does wellbeing mean for them? For me wellbeing for them means that they feel that they have strategies, or they have ways of managing their bipolar, so that it doesn't overwhelm them in their life…that they feel they have support to turn to when…when things take a dip…they feel well supported and they feel kind of umm…err…again I am struggling for words because it's like… I want to sort of say 'content enough' but maybe they feel okay about having bipolar disorder and they…they don't feel it's ruining their life…they just feel it's part of them and that's how…and that's how it is, but not in a defeatist way but just like, you know…it's just part of them but they…they… generally know how to manage it and that there's someone there for them when… when times are bad

I: Okay…so it's almost as if the bipolar is an example of the mental health…but then the wellbeing…you could have quite high wellbeing and still have a mental health…

R: it…what is termed a disorder… exactly…exactly…and now you see how that fits in with my kind of thinking that, you know, it doesn't matter if you have…you can have schizophrenia, you can a personality disorder…you can have all sorts of things…but if you have a way of living with it…in a way that err enables you to function well enough…in a way…you see what I mean…*and* have meaningful relationships with other people, then it's kind of okay…it's what…it's what you have

I: Yes…I see what you mean…and you…you mentioned back at the start of the interview that umm that you consider yourself not to be very *different* to the clients, but to have more coping strategies. Do coping strategies and wellbeing…are they kind of…something which fit together or is …? Can you teach wellbeing…?

R: Right…yes I know… I was thinking that …umm…I guess when I said coping strategies …from the minute I saw it I thought 'Oh, I don't like that word "strategies"

(laughter)

I: and I wrote it down! (laughter)

R: Yes…no, no…fair enough… What I really believe in is, if possible, is to have an understanding of why it is that you are the way that you are…okay? So given that I do have a very strong psychodynamic background…I do have a very, very firm personal feeling…that that is if…if…if umm…if one as an individual can manage that…because not everybody can manage that for a number of reasons…but for me *personally* that's the way that I deal with things…is that understanding why it is the way I feel that way makes it manageable…and so I can *never* be taught a strategy…I could never have someone to say, 'Oh if you do that you'll feel a lot better'. I would be…it makes me angry that approach I have to say (laughter)…okay?... because I find that superficial… However I do understand that for other people the strategies can be very helpful… (laughter). So I wouldn't dismiss …don't dismiss it…but I think for me it's all about an understanding what has happened to you or why it impacts you and the way you do and…and how it impacts

on your…everything you do…sort of, you know…for me …you know…the pasts and the present are very mixed up together and the future, because of…everything that's ever happened to you…and for instance what you do in the here and now ….right…?

I: Right…yes…yes

R: but I…and I think if…ideally for me…if people are experiencing challenges to their mental health, say, you know…umm…if they can explore those kinds of things and are able to reflect on them and…and be in touch with the emotions that…that what has happened to them arouses…that's the best possible route for them. So that's a strongly therapeutic route obviously…but what I feel I see and…err… is that not everybody can manage that…because not everybody has got the reflective skills…umm… to go through that, and…and for some people the pain is just too much I think…umm…and that they don't feel safe enough to do that…? This kind of a whole variety of reasons…so therefore you need other ways of helping people

I: and is that where then the coping strategies come into it?

372

374 R: That's maybe where the coping strategies…but I think coping strategies are only good if actually you do have
376 some very, very solid…people have solid relationships in their life. So for me I think isolation is the worst possible
378 thing that can happen. So that's one of the messages too I get from the umm post natal depression group. It's sort
380 of…get the mums together…and they all say as part of their feedback…'It was so great to know that I am not
382 alone', you know, 'that I am not the only one who goes through this'…'that I can just say things and it's okay', you
384 know, all of that sort of social support or just social acceptance, all of that is all it seems….I mean I know it is
386 in the literature as well but, you know, as what I see every single time I run a group. So there's…that sort of confirms
388 I guess…that all those other things I have about…relationships are *key*…and then what else you do
390 can work on that basis

392 I: and just to clarify before we move on from these coping strategies… What do we mean by coping strategies?

R: What kind of coping strategies…alright…okay

I: Just an example or two

R: So…a classic example would be umm, you know, the practise of mindfulness. So…umm…thinking that there's a…umm…right…so there's a particular intervention for…I think it's called 'Parents under pressure' for…if you have heard of it or not…

I: I haven't no…

R: It's for…it's for sort of the extreme end of err family breakdown let's say of relationships…umm…but rather than just sort of putting interventions in the relationship straight away…one of those strategies is to err teach mindfulness to the parents because in order….what err the research shows us…that in order to be able to foster secure attachment you need to be able to create space in

your mind for someone…you need to be able to mentalize about another person…you think about the person…right?...but how do you mentalize about another person if your…your own head is in such a muddle…no?...

I: Yes…yes

R: and how reasonable is it to expect people to make all these changes when they're sort of all caught up in their own mess…in their own…umm…trauma. So the idea is that by teaching them…umm…mindfulness…then they can create space in their own mind for themselves…but that by creating that space in their own mind, then enables them to be able to take on board…umm…the interventions and other things which will help other parts of their life and help that relationship, and I think…I think for me…so that's the example of how I think mindfulness is very effective…umm…yes. That's …I suppose that's the one…I'm…I think is particularly good…also because it's used with children and adolescents and umm we all know that the mind functions best when it is calmer and free of stress. So…so that's something that I would…I have often recommended or I have given people CDs…

I: So that would be seen as a coping strategy, but one which is quite… What…what are you thinking…yes..? (laughter)

R: Yes…sorry…yes…I probably made a face…but… it's a coping strategy issue

I: A face….(laughter)

R: Yes….'She pulled a face!'

I: (laughter)

R: umm…I would see that's a coping strategy if someone had managed to practice it to the level that when they were…they could… I think for it to be a coping strategy two things have to happen: 1) that person has to have… err… reliable awareness of when it is that they are in a challenging state, let's say, which is…I think people

sometimes have to develop that awareness… and the second thing is they will have had to practice mindfulness enough to be able to apply it reliably once they have that awareness

I: Okay

R: So that for me…that would be a coping strategy… If you teach someone mindfulness…you are not giving them a coping strategy by itself…you need to put the other bits in

I: Okay…so it needs to be well applied and…

R: and specific to that person…you need to help them embed it and think how it will work for them

I: and just going back to umm…the idea of…because in my mind we are still…we are still talking about this concept of wellbeing in mental health being two separate

things…which I think you have explained really quite helpfully…umm…but in terms of…so you have mentioned specific kind of mental health disorders…

R: Yes

I: Do you think that umm…that in building relationships and some of these coping strategies…do you think that that's just shifting the individual's capacity to *deal* with the mental health disorder…or is it actually able to shift the disorder itself? Does that make sense?

R: Yes…yes…I think…I think…oh yes, gosh, that's difficult

I: (laughter)

R: umm…I think both things…I think both things. I believe that by increasing the umm quality of the relationships around someone…it does actually lessen their mental

disorder…because I believe that most mental disorders, if not all, come from…relationships. So therefore if you build…good quality relationships later on in life…obviously I believe that you are going to mitigate… I mean…I also believe…you know…once a lot of damage has been done…I don't believe you can wave a magic wand a make it all go away…which is why I guess I think, you know, it's all about, 'Well how does someone live with bipolar?'…or other things, you know, rather than thinking you can just take it away. So there's that umm but also I…what I see…so like…some of the feedback I get from the antenatal thing…where the mums have a diagnosed mental health disorder…before we start…they do a questionnaire where *before* they will say that, 'Yes, I have a mental health difficulty and this affects me a lot' and then *after* the intervention they say, 'Yes, I have a mental health difficulty and it affects me a *little*'. So that sort of shows that the intervention has…has mitigated the effect of it

I: Which in itself impacts… the disorder…if it's having less of an impact it…

R: Exactly…exactly. So I think it all…(inaudible) together

518

I: and just to throw into the mix…so you have talked a little
520 bit about how umm, sort of *damage* has occurred, probably through relational aspects of one's life, which
522 then impact on a mental disorder…sort of nature versus nurture debate…do you think that there is a debate there
524 or is it …?

526 R: Ah!

528 I: (laughter)

530 R: Ah…well. The most recent research…because they are doing so much research on the development and the
532 foetus now…is that it is…there is no nature/nurture divide because there is an interaction from the moment of
534 conception. So…because they…do you know this research where…is at 14 weeks…a foetus of 14
536 weeks…they…if…they have looked at twins, twin foetuses, and there is a difference in the way that the

twins will reach out to the womb and the placenta…and towards each other

I: That's amazing! Okay.

R: So there's…and they will continue those particular movements that you can notice…

I: Wow! That's incredible!

R: Isn't it? ...Isn't it?

I: Yes!

R: So, you know, they are just so much more…and that's alongside all the research showing you the effect of stress in pregnancy and how it matches up with later diagnoses of ADHD…you know, all those behavioural things. So we

know that pregnancy is…there's so much interaction going on there…and the foetus reacts so strongly to what is happening to the…to the mother…and external things that it's…it's all, you know, it's happening from the very beginning that interaction, so you can't (inaudible) them apart…umm…and also there's epigenetics… so that you could be *born* genetically with a disposition to something but that what matters is if those genes are switched on or switched off…you know? So…

I: Mmm…yes

R: Sorry…sometimes I am talking to you instead…but I don't mean to talk to you as if you might not know this

I: Oh no, no, no…I am just…nodding….knowing you…most of the time I am like…

R: (laughter) It's for the tape (inaudible) (laughter).clearer if I sort of just waffle on

(laughter)

I: Waffle away…it's so great

R: Right…that's alright… So, because of the whole epigenetics thing which gets switched on/switched off, then that shows that, you know, how…just how important the nurture aspect is, because you can go against the genes, or you can amplify them massively by their nurture. So what…yes…so okay (inaudible) so on one hand you can't tell them apart but all the research is showing us that nurture side of things is what shapes us

I: Yes, that makes a lot of sense…very interesting indeed. Oh dear, I have got myself very hung up on this first section, because this is…you have got some really interesting opinions, but I am…

R: Can I just add…I know this is not my opinion, but what I have noticed generally is that if you are in education you talk about emotional wellbeing and if you are in health you talk about mental health… and they kind of mean the same thing, it's just that education doesn't really like talking about mental health…it gets all 'uppy' about it, and then…and then there's the whole kind of medical model within health that likes to have its diagnoses and things…although not everybody obviously agrees in that in both camps, but I think a lot of the wording is just it's umm…it's 'smoke and mirrors'…it's kind of

I: but this…I mean this is the interesting thing isn't it…because I…well I'll…yes…because I…yes…anyway

(laughter)

R: that's one of the reasons you are doing this, isn't it?

I: Yes, yes…umm…so I will quickly ask… Do you think that…we have talked quite a bit about diagnoses, but do

you think that that's a helpful concept, having a kind of…a diagnosis?

R: (laughter) Yes, that goes to the heart of a lot of EP practice. I guess personally I do, because I think as a human being often, and I guess I mean as an older human being, so this would be adolescent onwards or…but even… I don't know… sort of maybe you are eight years old onwards…having a way of understanding what's happening to you is helpful, and its…as long…obviously it depends how people react to that diagnosis or what happens next, all of that…but I think potentially, to be able to look and see, 'Oh yes…oh look, yes, this sort of explains a bit why I feel the way I do, why I act the way I do'. It can be…it can be…I mean definitely it can be liberating; I have seen people have, you know, have diagnosis and they feel like a huge weight's been lifted off them…umm… So yes, even though there are lots of problems…I think the problems about diagnosis about, you know, putting people in boxes and umm medicalising them…that stems from how people treat diagnoses maybe...sort of more from systems and culture than, you know…maybe a diagnoses itself?

I: Yes, that's a good point...

R: in a way?

I: Yes, in that kind of idea that's stigmatising is…that's more the issue, and as you say that's a systemic problem… (laughter)

R: That's a systemic problem…exactly…and if, if a service is treating the diagnosis rather than the person, again that's a problem that the service…

I: Yes…absolutely

R: I would say

I: Yes…that's an interesting take…umm…and umm…so my last little question from this section was umm…What

would you say has influenced your understanding of everything that we have just talked about? Can you think of what ….

R: Yes, the very easy answer to that is…is my own experiences of childhood set me off on a path to understand, and then…and it…it drew me towards umm…it drew me towards being a child psychologist or a chid psychotherapist from adolescence onwards. So in my…kind of always thought I'd go down that route, and I just did the teaching bit because I wanted a bit more space and…and I wanted to get myself together before kind of doing it. So, yes, I would say firmly it's about me understanding in my own childhood and myself that…that started…that, yes…behind it all

I: and that sort of drove the journey…and then, actually what I've picked up on was you've been talking…you've used a lot of kind of, 'I've experienced' and 'seen this' and 'I've…'and so it sounds as if a lot of your kind of understanding has been not only kind of shaped but also emphasized by what you've seen in reality of…

R: Yes

682

I: how people have responded and…

684

R: Yes…yes. I suppose it's an interplay…because I think I
686 have…I have read a lot compared to…perhaps other, you know…other colleagues, because it's been my thing and
688 because I've done that specific Masters, (inaudible) a lot of reading and writing and I write articles and stuff…but ...I
690 guess it's that…it's that sort of ecological validity thing, whereas if I read something and I can see it…as well and
692 my experience in my job then I kind of think…that seems to fit

694

I: Yes…and that stays

696

R: Yes…so it stays…whereas if I read something and then it
698 doesn't get backed up by experience then I am not going to go for that theory so much

700

I: It's like a fair way of …approaching things. Okay, lovely…oh gosh, I can tell that you've got lots of well thought through thoughts on this, because we've talked a lot about the definition rather than… Moving on to section 2…so I would like to talk to you a little bit about the role that you perceive yourself to have as a clin…educational psychologist…umm…in this area

R: It's interesting your slip…Freudian slip though isn't it…you know…about to say clinical instead of…that's interesting

(laughter)

I: that is interesting…yes…let's move swiftly on…umm… So I guess I am specifically trying to look at secondary school context…so if you can try and put on (inaudible) secondary school hat

R: Yes

I: So what role would you consider yourself to have in supporting, I guess…I'll say mental health umm of adolescents…as an EP

R: As an EP…okay…so when I answer that do you want me to answer umm…do you want me to answer in a theoretical thing that if…if…if I was working with a secondary school, what would I consider my personal role as an EP, or what do I consider the role of EPs?

I: Are the two very different?

R: Yes…potentially yes

I: Oh…let's do both

R: Let's do both…okay

I: Let's do both, yes

740

R: Simply because I think…right…so if I…so what could be
742 my role with mental health…right

744 I: Is… this is what your…

746 R: Me

748 I: preferred role

750 R: This is…this is what I personally could do…I am thinking...
so *personally* what I could…so if I...if (inaudible) were
752 forever I get involved with a…secondary school age young
person…I always No. 1 I think of their mental health, so
754 even the referral has been for something completely
different…I think for example, What role is anxiety playing
756 in this situation? …What role is stress playing in this
situation? So I…I view the whole situation… I analyse it

from that point of view…and so I'm not just looking at it to say… Well, okay they are not accessing learning here because of this cognitive difficulty…I am thinking… So what is it about this situation that they seem to find…you know…challenging?…and I think for me, because of my sort of maybe broader view of what mental health is, I will be thinking…is…I suppose how…how is that person…young person's mental health? So then I… so then for … systemically I guess…I kind of think… So what is that young person's day like and how can we make them feel more safe and secure? Are we applying attachment theories… I'll be thinking… Where's their safe base?...you know…Do they need a key person who…do they need someone to sort of show interest in them who they can do that…umm…emotional sort of dipping in and out of…umm… Who could be…be that function for them…umm…and their peers, you know, what could go in to help them feel…thinking about the adolescent development and the importance of peer groups and significant people…How do we get that there?....sorry, go on

I: No…so how do we get there…so I was going to ask, What …

R: yes…what kind of (inaudible)

I: what would you role…then…yes

R: Okay…I think the analysis is important…I think that's what EPs can do…umm…in general is they can have that really broad view and then… So if you think about something like the theory of change…do you know about the theory of change?

I: Go on…tell me a little bit more (laughter)

R: It's a big…it's where you sort of think … What are all the possible outcomes…that we are looking for? …and then once you have identified all the possible outcomes you then look at all…in the individual areas…what you can do and how you would evaluate it

I: Right…and you are doing this with the young person or…?

802

R: Yes…now…yes. Oh yes it's crucial isn't saying
804 that…yes. So for me the young person is key, their the person I listen to most…because if they are telling me and
806 I am …or I picking up that they're really unhappy or anxious or stressed or something…that's the most crucial
808 bit of information for me I guess…and then I kind of try and (inaudible) with everyone else. So (inaudible) kind
810 of overview of theory of change things. So then we go down into particulars…so if it's a friendship thing – might
812 be circle of friends…might be appropriate, depending on the age…err…or it might be something more specific than
814 that…umm… I could potentially offer 1 to 1 solution focus brief therapy, since I am trained in that… So I could offer
816 them that to help them think about how they can get more out of their experience at school…in their life

818

I: (inaudible) stuff and

820

R: What's that…?

I: It's a resource…activating and…

R: Yes…exactly, exactly…and then…and I think for me…I like that because it's about self efficacy…the fact that, you know, you do have a role in your own life, you know, sort of to counteract the passivity and helplessness. So if you can feel that actually you can make a difference in your own life…that for me is a crucial part of mental health…good mental health…right?

I: Interesting…yes, yes

R: So that…that would be a crucial thing. If I felt that the teachers or the TA or someone like that really didn't have a handle on this young person and what they needed to do, then I would offer **(inaudible)** interaction guidance with the teacher, or something called video enhanced reflective practice for a whole group of professionals…so I could offer that…systemically or indeed if…if the main problem seemed to be the parent, then I…you know…my offer of

interaction guidance and the young person to…improve things there. So it sort of depend where it came out…umm... Okay at what point do I refer to CAMHS?...umm…obviously if the child is suicidal, having suicidal thoughts, I refer straight to CAMHS…umm… I know it's very difficult to get in…that's about the only criteria they have for accepting a referral up here so…you know. I obviously do refer to…I have referred lots of young people to CAMHS if I think that they could, you know, benefit from umm bit of ongoing family therapy…(inaudible) tends to be what they offer up here

I: and would you…in…so you use the example of a young person were suicidal...would you immediately make that referral or would you have any input in that situation, other than doing the…

R: If I thought the young person was err…suicidal…I would try…I am aware that I am not trained to do a mental health assessment, and therefore if I…if I…if there was some alarm bells ringing about how err desperate that person felt…I would err talk…so I would tell the young person I needed to talk to their…I don't know…if their parent was

there or their teacher, and say that, you know, I was very concerned about them and I would try to ensure that an emergency mental health assessment was made on that day

I: and…because there is an inpatient unit in Lowestoft is there…did I…?

R: Is there?

I: I think there might be…anyway that's another story

R: for young people?

I: Yes…I think there is

R: Well I do know the processes that you…if you are concerned about someone umm…being suicidal…then,

you know, the people who can make that assessment are either GPs or the psychiatrists. So it's important that I don't try to make that assessment myself....umm… so, okay… on what grounds…do you now I am just thinking this through…because if someone sort of says about, you know, if they are self harming I don't…I wouldn't take that as suicidal…that's obviously very severe but, you know, it's not suicidal…umm… if umm…it's more complete lack of hope and if they…if they told me anything like they had plans or they…obviously if they could tell me I know one of the things that they could tell me in detail about how they would do it…that's…that's like I am not letting you go until you…you know…someone's accompanied you somewhere…umm…but on the other hand I said, because I am aware that I am not trained to do that mental health assessment…and it's important that I don't pretend that I am. So it's trying to…strike a boundary

I: Okay. So…where…where did we get to answer the…the role that the educational psychologist …

R: So…okay…so I was saying this is what I would do because this is what I am trained in…umm…okay

I: and that's very interesting because you feel you've got the training and you feel equipped to do those things so…yes…go on

R: Yes…umm…right…so what do I think the EPs could do generally?...umm… I know EPs have worked with CAMHS to do the targeted mental health in schools training, so there is a sort of that systemic thing and to help schools umm work out their systems…so what do they do?…how do they notice and when they notice…umm…young people, you know…it's distress, what do they do about it? So I think having help in the schools to work out plans for that kind of thing is really helpful…umm…and also helping to work out a plan for how do they support staff who are kind of trying to support the young people with mental health issues is a huge thing…so there is that wider level…umm…then…so…I referred to mindfulness earlier (inaudible) our service is quite a big push towards mindfulness and people are currently training in how to train others I think…or how to do interventions. So I think running interventions on umm improving mindfulness skills with young people is helpful, because it's one of those things that as I said sort of creates a bit of space in your

mind and so you … sort of not plunging from one thing to another…umm…and I think where other EPs have got very specific skills

I: Right…so it's a lot about the training that individually EPs have had

R: Yes…because I think not all EPs are comfortable about err mental health and they absolutely don't see that that's not…that's their role, you know, but people have come into educational psychology I think from very, very different routes and different heads, and so, you know, people feel very (inaudible)…it's a huge range

I: That's a really helpful perspective…and do you think that that's…what are your thoughts on that? Do you think that's a difficult…issue for the educational psychology service or is it a positive that people…?

R: umm…I suppose you could say it's a …I think it's always a positive if people have got different strengths in the

service. I think if you have the flexibility in the service, that actually we probably have got now…that…if schools are requesting support around a specific issue, you can identify the person in your service who has that expertise and use them, then that's great

I: That's…yes that's positive

R: …that's helpful. I think perhaps old style, where…where we were in a situation when we had…we were all allocated to schools and we dealt with our own schools and all of that, then it becomes more of an issue because one school is a whole…you know there might be 30 schools who never ever get any kind of that input and other schools who get a lot of it

I: that's a very good point…yes

R: so, you know, but now…and then we've gone through a phase of umm...we can only deal with the most severe and complex, and I suspect that mental health is…gets left

out because it's severe and complex ones that could be the ones who have complex learning difficulties…although obviously we have got the exclusion ones, but ...So anyway, but that's a bit more…it seems a bit more hit and miss because potentially you are getting those who are just treated, the complex ones as a learning issue and not seeing the broader picture…and I think that is a…that is an issue because I don't think it's ever just learning…umm…whereas perhaps now we are moving towards a more flexible thing, because we are traded…

I: that's a good…yes

R: that so…yes…it could be a good thing

I: Yes

R: It could be a good thing…and it's also (inaudible) because of like lack of CAMHS where once, you know, we worked very closely with CAMHS and, you know…it was very easy to understand about when we would refer and

that…that meant that you wouldn't think of doing certain things because you knew that CAMHS would be able to pick it up

I: Right

R: whereas now we know that CAMHS…yes…again is, is decimated and it's very, very difficult to get a service. So…so you know, you think, you know…Well those poor young people…where do they turn to?

I: Yes…okay…that's really interesting…so when…so you…kind of are remembering a time when it was different. How long ago was that when CAMHS was more available? When did it become decimated?

R: Four…years ago, maybe? Yes… or is it 5?

I: Okay…and it's …has it…just has been …stripped right back …is that the…?

R: Yes…because of all the…umm…what are they called…the things we go through…? …various reorganisations…sorry…and re-banding and all the different things…and our mental health team has gone from being a…what were they…? I think they were XXX and XXXXX…but they are now…they are Norfolk and XXXX. So they have gone through a couple of sort of organisational changes and, and constantly an upheaval, so there is a lot of staff that have…have been made redundant from it. There are literally far fewer people there…and the people that *are* there…there's…might be changed now…but there were…for a time it was mainly primary mental health care workers and hardly any psychologists or….psychiatrists…so…umm…yes

I: So sometimes EP involvement with mental health is simply out of necessity because there is no-one else to do it…is that …?

R: Yes…I, I feel that…that would be my personal view… that that's what would happen, but having said that it's true…it's also true that umm… We have been through this period where because we can only pick up the severe and complex…and time is very short, then if you are going to err do...give proper support for people with mental health difficulties, then you need time…don't you…you need to be able to see them over time and…that…

I: for those individuals

R: for those individuals and therefore, you know, that isn't something that as a service we've always been able to do…and we could do it more and then we…we've been able to do it a lot less, and then…now schools are requesting EP input then I can see that they might sort of buy us in to do that kind of thing

I: Okay…so I was going to ask what sort of things…how do the teachers and school staff perceive our role in this area? Do you want to elaborate on that a little bit?

R: Gosh…I think…I think that's a tricky one to answer…because things have changed quite a bit in the past err well if we said five years…I think there has been a lot of change. So what they have experienced is them having less and less EP time. So like five years ago we'd be at a planning meeting and would be saying, 'Oh, we can do this, and this, and this…' you know…would be inviting them to err, you know, allow us to come in and do various things…and then that sort of…that dwindled and then they…now they don't have err planning…we haven't had planning meetings for a couple of years…and so they can only refer for precise things. We are more likely to say, 'doesn't meet our criteria…doesn't meet our criteria'. So they have been used to not having EPs, so they wouldn't even minimally think of referring to us…I would think…because they …

I: for mental health type stuff?

R: Yes…I mean they know that they can refer to us now if…it's incredibly severe…it's only in the credibly severe and complex…otherwise we are not going

come…umm…and like at the moment…informally I know that people have been saying that the people they…the children they see umm…as requested to by the schools…on the severe and complex…those are the children then end up getting EHC plans…so we're not seeing the children…don't seem to be seeing many children outside those EHC plans… So that tells you how…how narrow things have become…but with the trading now opening up…and through schools choice, us saying we can do this…we can do that…*now* requests are coming in for us to do more of that stuff. So, for example, I did …I did a…training to a high school on attachment the other week…through this traded…

I: Through the traded…yes

R: So I can see more mental health things coming through that

I: and you don't think that schools would ever see an emerging mental health difficulty as one of this severe and

complex ...it just does…does it just not fit into that severe and complex call that we offer?

R: I wouldn't have thought so…I think there is so many really, really, really, really complex children at the schools that…for it to hit our…stuff…my (inaudible) be off the scale

I: Yes…so…and when you say there's lots of really, really complex…are we talking about learning difficulties here or….?

R: Mental health difficulties….if you said to me like…I know…take a XXXXXX school…take XXXXXXX Primary…If you said to me, 'What level of mental health difficulties do you think are in that school?'…just amongst the children…let's not go there with the staff…

I: (pause)

R: I would think …I…without exaggeration, I think you could easily say 40 or 50% of those children have some kind of mental health difficulty…where they're not functioning as well as they might do…because… because of the…the complexity of their lives…because of their high, really high levels of social deprivation…because of the intergenerational attachment difficulties, you know, all…all of that stuff…and so the ones that sort of… we get to see are just like the tiny tip of the iceberg

I: Who are they…the ones that we get to see….?

R: Well I think that they are the ones that have got umm…where things have just gone massively pear-shaped, or where the children who have significant…maybe they have a…they have a learning disability and a physical disability, and their behaviour is, you know, all over the place…and something else…you know what I mean…it's kind of like the whole works…the whole works…and that's the ones that we (inaudible) see…who are really, really struggling to function in mainstream

I: Right…that's a really complex…

R: Yes

I: I am just aware of the time…we'll quickly…we've talked about most of this already, but the last section is around what your perceptions are of other professionals' roles…umm… So you mentioned the teacher's role in the context of CAMHS…umm…and…but…yes…what sort of role do …?

R: Do you think they have?

I: Yes…what roles teaching staff have and …

R: I think ideally …ideally…they…well, they should be attentive to young people…enough to notice if the young person is experiencing distress. So if I say experiencing distress I mean, you know, there's a potential mental

health difficulty there…and I think they should be thinking about the young person's behaviour. So if a young person persistently comes in late…they need to think why is that…they need to ask themselves…you know…could it be something else, you know, like…a classic one is could they be a young carer for example…you know…but just like asking themselves these questions or…if err…rather than treating young people as behavioural difficulties…so think…What is this behaviour telling me…right?

I: Yes…it sounds simple, but actually that would be…quite a shift wouldn't it

R: Yes…exactly, exactly. So I think, you know, No1 that's it…but if they ask themselves…what is this young person trying to tell me by…through their behaviour…and…and being a bit curious about it, rather than just err you know, dismissing and sending them out, and treating it as umm…the usual issue…that…that is…would be the first step umm… I think, obviously what I would like is all teachers to be really kind to their students…so, you know…that's not always possible in a big class…I…I…I get that, but it's about making time for their

students…umm…sort of showing interest and being kind, and sort of thinking with the student… Well what might help?

I: Yes…and presumably building a relationship through that…that's…

R: Exactly…and if that teacher can't manage it, which is kind of fair enough, I get that...it's about identifying with the young person… Who could do that? So which…which person in the school…because there are sort of lots of pastoral people and TAs and stuff like that…Who is there that that young person could like regularly check in with and…would it be better if that young person spent like, you know…good…good high schools will do this…they will now that home life is really challenging, and so that the young person comes in …the first thing they do is spend time with a, you know, warm, responsive adult umm…to sort of make that transition...and then they can come into class and function better…and then if they need to take themselves out during the day, they do. It's sort of that kind of thing really…yes…not dismissing…young people… but thinking about them

I: So actually having a role….What would you anticipate the teaching staff's role to be…if they *were* to identify some kind of…behaviours that they couldn't…make sense of?

R: Yes…umm…well…I would expect them to use their own pastoral system. So as a tutor there's always some kind of senior tutor isn't there…there's always some…whoever's role…pastoral role it is. I would expect them to go to that person and talk it over…and to think… What...where could they possibly err get help from?...because it…because if, you know, an awful lot is demanded of teachers (inaudible) huge amount…huge amount…and I don't think they should be making these decisions by themselves, because they've got so much to do and think about…but…there should be a system in school like that…and then you can think… Okay, so what does this need? Does it need our own in service…I don't know…some schools have got counsellors, some schools have got family support workers. Do we need to do a CAF here?... you know… Do we need to get a multi agency intervention together?... you know…What are…what the services in our area that we have, that we

could draw in here? I would expect them to do that kind of thinking

I: and there are those resources there...

R: Yes…different areas have access to different resources, but there's always a CAF…and so if, if home life is really chaotic and, and umm difficult, you know, perhaps there is a mum there who needs extra support and, you know, err, you know (inaudible) things isn't it, you know, maybe the young person…I don't know…maybe the birth father's just come out of prison and, you know, so the whole family needs a bit of help about …keep things safe. There's always something isn't there? So it's, it's about who can you gather together to think

I: Yes

R: Okay…so that I am saying there is I am seeing it more as is an ecosystemic problem there?...and is it…it's…a lot of it is in the environment, and actually the poor mental

health there is simply a perfectly reasonable reaction to (laughter) what's going on…and actually if you put in enough support and thought around that, then it's not about mental health services. So mental health services… 1) I think they can be a little too looking within the…within child…within the person…umm… but so I would see the role of a mental health service more as, you know, then… obviously wonderful if they can offer some ongoing therapy so, you know, for a safe space umm you know, a safe space…a bit more than that isn't it? I mean, you know, high…for a highly skilled therapist to be able to enable them to explore things that have happened in the family that are still affecting them both, and to enable them to say things to each other, that kind of thing

I: So I was going to ask what you think the role of the *clinical* psychologist would be? Is that the highly skilled…

R: For me it's…it would be sort of the…the ability to give err quite a bit of space to exploring err trauma…let's say, because it's usually trauma of some sort isn't it? So it's about exploring it together and enabling members of the family or it might be just the young person with someone

else to…to voice really…to find a voice for what has happened and enable them to say things which they perhaps haven't been able to say in everyday life…and… and I think that's very helpful and…and for people to be recognised, you know, to be seen and recognised…and that sounds very basic but I think often that's what happens that, you know, if the (inaudible) ongoing trauma and the other person isn't seeing because it's just everyone has just got their heads down and umm

I: ploughing on

R: powering on…exactly. So…so yes, I mean, I (inaudible) clinical psychologist skills in doing that kind of thing err a lot. I also, *personally,* I like… I like it if there is some therapy offered 1-to-1 with the adolescent…because obviously I agree that its better if the whole family can change, but I also think that a whole family…you can't make them…and sometimes the adults can't change at that moment…but the young person still needs support. They need to know it's not them…they need to know they are not mad and they are not at fault…and therefore if you

can't work with the whole family, I think you should work with the young person, to help them

I: and what would that look like…would that…those individual sessions…would they have a particular structure or would they be…?

R: Well it depends on the background doesn't it…of the therapist. Yes…yes…so as you can see I'm not…I wouldn't be in for CBT…I would…umm…I don't like CBT err…. I feel that it's more helpful for people, you know, err...to (inaudible) sort of understand, to be able to 1) acknowledge…recognise…acknowledge…explore their feelings and thoughts… and so if you are going to recognise and if you are going to do all that that's much more a psychodynamic or umm, you know, a person centred approach than it is a CBT approach

I: Fine

R: CBT for me is a sort of a …it's a coping strategy…so…and you know what I think about coping strategies

(laughter)

I: That's…that's…no that's fine…you are being very consistent…and umm...

R: (laughter)…good

I: and do you think that clinical psychologists have a role with the school? Do you think…how does that work?

R: Do you know what I think…I think…I think they do in so much as it is helpful for…for… I mean school staff cry out for some kind of feedback from clinical psychologists…to sort of say… So please tell us what we should do…and what they mean is, you know, don't want the clinical psychologists to say, you know… Don't back him in a

corner, you know… It's really important that you don't loom over him, because you remind him of his abusing father…so keep your space…keep your distance, you know, they actually want very, very practical stuff like that, whereas I think clinical psychologists think that they mean some sort of much more deep and meaningful stuff. Whereas school staff want kind of very practical, concrete things…and they need to be told…they need to be told, you know, leave this kind of space…let the person make the first contact, you know. Why wouldn't they need to be told? They are not experts in…in those things. So there's a bit more understanding of each other's position, oh yes, but on the other hand the…obviously school staff don't kind of…there's all this mystique about therapy and if you haven't been through it yourself you kind of…it seems mysterious and…who knows what goes on in there. So I think that there's a bit of umm mutual understanding…shared understanding

I: That needs to happen or that is….?

R: That needs to happen

I: Okay

R: Yes…that needs to happen…yes…for…for each other…but I think it would be really beneficial…but obviously it takes up a lot of time, so I think it's more about…and school's need to understand that it is completely inappropriate for the clinical psychologist to *share* what's going on in therapy...unless it's the young person wants them to share it…so it's all of that…those boundaries…but I think, sort of some sort of feedback about, you know, Please can you ask Mr 'Green' to …

I: to stop looming

R: potentially ….to stop looming…exactly, you know, to be aware that that's actually the triggers are very traumatic experience for the child. I think that's kind of really helpful stuff

I: and…but you don't feel like….that actually happens in reality?

R: It's not something I have seen…I have seen more the kind of lack of understanding on both parts…of when…when clinical…when (inaudible) psychologists and I have…I have been at the meeting as well. I have seen a bit of a lack of…kind of…you know. Each other's aims are very different, and I think clinical psychologists don't…aren't used to sort of stating their aims in very precise, clear ways…and that's…that's a bit of a broad statement isn't it…about poor clinical psychologists? But I think there's something about educational psychologists who are very used to umm…stating things neatly and clearly, transparently…umm maybe more concretely…probably because they are not therapists umm…in a way that clinical psychologists that…I have seen them struggle to do that

I: and then just my last question…umm…So you mention previously that there was a lot more kind of overlap and work with clinical psychologists

R: Yes

I: umm…but not so much now?

R: Yes…definitely

I: So… perhaps if we just really quickly umm talk about currently…is there any kind of joint working that you do with clinical psychologists?

R: No…no…and it wouldn't cross my mind to even err attempt to refer somebody I don't think

I: Unless it was a child who was acutely suicidal…and then you would go…

R: (inaudible)

I: and what about previously?

R: Well previously I would…I would refer people, phone up to talk over a child…um I would go along to meetings…so when they had, you know, would…what would happen is that say someone…a family had been referred in, or maybe I had referred them in…at that initial meeting umm or the second meeting…I would be invited along to it…so I would sort of take part in it…and sometimes I would be the conduit between school and…and those therapy sessions

I: Absolutely…yes

R: and that's kind of useful (inaudible) because of the clinical psychologists doing these sessions they are not being able to deliver the therapy. Yes…umm…yes…so that's…that's…that was…I mean obviously that was really great…that was great to sort of work alongside and, you know…

I: Were there any kind of specific challenges that you could think of in terms of the way that you worked?

R: I think the only one would be…the only one I can think of is…if I am invited along to a meeting run by err the clinical psychologists…I am sort of the guest in the meeting…right? So I don't like to challenge what that person is doing in the meeting…or what they are not doing…umm…and…whereas I want to (laughter)...so I don't mean that in (inaudible) I just mean…I just mean I want to say…I want to say things like you know, 'What do you think the family understands from that question? …because I guess it's part of that observer thing where you are looking, you are thinking…So this guy's asking these questions and I…on…from the look on their faces are all thinking…What the hell is this all about?...and at the end of it, when they have sort of…just sort of summed up and sort of said…Well if you have found this kind of useful…well I am thinking…they think we are just chatting, you know…I know what you are doing…but they think we are just chatting…and so I want him to say…'and the reason why we've been doing this is because blah-blah-blah'…I want him to be a lot more transparent about the process and what it is. So it is something…I guess I am used to being very collaborative...checking out err and all

of that, and…and that's what I want to do in a therapeutic session as well…at some point in it

I: You've (inaudible) a couple of times…do you think that's mainly down to the training differences from clinical and educational because…

R: it could be

I: it feels as if educational psychologists… just a lot more kind of … transparence… that I think that's a really helpful word…just kind of…less mystery

R: Yes…less mystery and I think…depending on the EP…but more collaborative…and I think being collaborative in clinical psychology there are clinical psychologists collaborative but it's a bit of a…it's almost a new thing that's come into clinical psychology, that I don't think it…it's definitely not…wasn't used to be there…that…and also clinical psychologists get caught up in the processes a lot…and I get that because they're therapists but…I

think…I feel it's kind of good to step outside…being caught up in the process

I: Yes…yes…and that, yes…its…you sort of think of **(inaudible)** psychologists who would do that anyway (laughter). Okay…that's all my questions, and we have run over by a few minutes, but do you have any sort of last thoughts that are on the tip of your tongue…or anything that you want to….

R: Just…umm…I don't know…just I suppose I do see there is a…I do still believe there is a difference between educational and clinical psychologists. I do see clinical psychologists as being the ones who kind of mainly deliver therapeutic interventions and…whereas educational psychologists might do therapeutic work, but they umm…they might not do it ...they might deal with the same level of young people and difficulties, but they don't maybe deliver the therapy to the same level umm…and I think another…I tell you what is a mega issue here…and that's about clinical supervision. So I would feel strongly that, you know, if you are a clinical psychologist you get clinical supervision…and that happens. If you are an

educational psychologist delivering therapy interventions you don't necessarily get any supervision around it

I: Ah….good point

R: …which is dodgy. I don't…you know...but…so

I: That's a really good point

R: I think that's a …that's a huge thing

I: Yes…yes. Oh…I could (inaudible)

R: Yes…no…because that's…so that is actually a huge kind of gap…that, that would need…

I: Do you think that's a limiting factor in…EPs being able to do therapeutic…or…?

R: Yes…and I think it's a …it's unethical in some ways…and you need to have clinical supervision if you are doing clinical…kind of…some kind of therapy intervention. So ideally wouldn't it be wonderful if clinicals and educationals could work more closely together and kind of help fill in each other's gaps…you know…that would be ideal, but I think for that to happen there would need to be a huge increase in the amount of clinical psychologists

I: Right…so that is…and that's useful again being a kind of reoccurring theme that there's just a lack of …

R: Just a huge lack of them…so just not enough of them…and I think there is a bit of dumbing down of the health service because…it (inaudible) lots of my PMHW's the umm…they are not parinatal…they are the primary health care workers…sorry…lots of those, you know…they do amazing stuff and I have absolute, you know, respect for them…but I think when you are

employing lots of them and less psychologists…I think you are dumbing down the profession as a whole…and so I see that a massive, massive challenge…umm…but, you know, for EPs to do more of the work…they shouldn't unless they really receive clinical supervision…because they are toying with it

I: Oh…yes

R: She says (inaudible)

I: It's interesting to see how it all develops over the next few years

R: Yes…yes…and if we ever get the joint training that was (inaudible)

I: Yes…it's still being muttered about…it definitely is…there is still some…yes…anyway…

R: So maybe that would help

I: Maybe that would help…yes

R: because you would get the basics the same and then you would just sort of specialise in different areas

I: and do you think it would be partly around actually understanding each other's roles a little bit better…or is that not so much the issue?

R: I think…I think we should share each other's roles a bit more in that case. It's not just about understanding it…(intercom sound) What on each is that? So…(laughter) (intercom announcement)

I: that's hilarious….

(laughter)

R: It's the first time they have done it ever…I bet…umm…you know what I mean…if…it's more about the (inaudible) understanding…not of each other's roles but of the work. So if educational psychologists had a bit more of a clinical background…and the clinicals had a bit more of an educational background…I think that would benefit the young people

I: Yes…yes…oh gosh we could keep going but I am going to stop us there

APPENDIX M: SAMPLE OF REFLECTIONS AND NOTES WHILST DEVELOPING THEMES

Reflections on Developing Sub-themes and Themes regarding RQ3: How do EPs perceive the role of CPs and others in supporting MH?

Emerging theme	Notes/Reflections
CPs diagnose and treat more significant needs than EPs	*Ambiguity around what EPs are classifying as "significant needs".* *Aware of personal frustration at EPs appearing to be less skilled or equipped to support MH needs.*
CPs work with families	*EPs work with schools – complementary roles?* *Does this imply that each profession can only work with one system around the child? Personal experiences of working closely with families in my previous role – there's great value in parents' perspectives and support; families important. Does this place greater value on the CP than the EP? Careful about comparing <u>value</u> of different professions, not that straight forward. My professional defensiveness?*
CPs work with individuals therapeutically	*EPs work more holistically – complementary roles?* *Query how beneficial therapeutic work is if strategies are not generalised to different areas of the YP's life. This is not explored in data so don't make assumptions.*
A focus on dealing with problems	*Aware of own training/powerful discourse <u>against</u> deficit model of working. Don't undervalue, or assume that work can't be complementary. Perhaps in an ideal/utopic world there would be no MH difficulties, but currently they are, so important to manage them.* *Dealing with "problems" does not necessarily equate to a deficit model of working.*
School staff should invest time in children – pastorally and relationally.	*Similar view to CPs regarding schools' role.* *Attachment theory, nurture groups?*
Shortage of CPs and thresholds too high	*CPs feel there are not enough EPs – be aware of the different perspectives.* *Easy to see the faults in other systems, and identify simplified solutions without knowing the full picture. Aware that I am a TEP – in the interview, EP participants may have felt more able to vent frustration as assume I would be able to empathise.*
CP sees child in clinic	*Assumption from participant that this is bad. Aware that my training and background led me to <u>not</u> challenge that assumption. Why is it better to see the child in school? Be careful to justify this using the data.*
Feeling of uncertainty around the CP's role	*And vice versa – CPs unsure of the EP role. What are the implications of this? That there is a less effective joint working? Don't make this assumption – see*

APPENDIX N: EVIDENCE OF ETHICAL CLEARANCE

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Dr Helena Bunn **REVIEWER:** Luis Jimenez

STUDENT: Rebecca Miller

Title of proposed study: An exploration of Clinical psychologist and Educational psychologist constructs of mental health in the context of secondary school aged children.

Course: Professional Doctorate in Educational and Child Psychology

DECISION *(Delete as necessary)***:**

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required *(for reviewer)*:

Ethics form sent only included the Invitation letter as a separate attachment

Consent Form was not included

Needs to:

1. Insert the Invitation in the Ethics Form
2. Attach the Consent for in the Ethics Form

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Rebecca Miller 

Student number: 1326690

Date: 28th February 2015

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

☐ MEDIUM

☒ LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer: Dr. Luis Jimenez

Date: 20.02.2015

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

APPENDIX O: TRANSCRIBER CONFIDENTIALITY AGREEMENT

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Researcher:
Rebecca Miller
Email: rebecca.miller@[redacted]

Project Title:

An exploration of Clinical psychologist and Educational psychologist constructs of mental health in the context of secondary school aged children.

This research is being carried out by Rebecca Miller, as part of the Professional Doctorate in Educational and Child Psychology at the University of East London. The purpose of the research is to explore the ways in which different professionals conceptualise "mental health" when working with adolescents; consider discrepancies and similarities in their perceived roles; and through identifying themes in these areas, suggest ways in which Clinical and Educational Psychologists could provide more effective and complementary services.

Please consider the following statements before agreeing to assist the researcher through the transcribing of raw data:

> As a transcriber of this research, I understand that I will be hearing recordings of confidential interviews. The information on these recordings has been revealed by interviewees who agreed to participate in this research on the condition that their interviews would remain strictly confidential. I understand that I have a responsibility to honour this confidentiality agreement.
>
> I agree not to share any information on these recordings, about any party, with anyone expect the Researcher of this project. Any violation of this and the terms detailed below would constitute a serious breach of ethical standards and I confirm that I will adhere to the agreement in full.

If you feel able to adhere to the above statements, please sign the agreement on the following page and return to Rebecca Miller via email (Rebecca.miller@[redacted]) or via post

(Community Educational Psychology Service, [redacted]).

Many thanks for your help,

Rebecca Miller

I, (please print name)…… agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the content of the interviews in any form or format (e.g. audio file, CDs, transcripts) with anyone other than the researcher.
2. Keep all research information in any form or format (e.g. audio file, CDs, transcripts) secure while it is in my possession.
3. Return all research information in any form or format (e.g. audio file, CDs, transcripts) to the researcher when I have completed the transcription tasks.
4. After consulting with the researcher, erase or destroy all research information in any form or format regarding this research project that is not returnable to the researcher (e.g. information stored on my computer hard drive).

Transcriber

Please print name: Signature:

Date:

Researcher

Print name: Signature:

Date: